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100th Congress
2d Session

COMMITTEE PRINT

WMCP: 100-29

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

BACKGROUND MATERIAL AND DATA ON PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS

1988 EDITION

MARCH 24, 1988

Prepared for the use of the Committee on Ways and Means by its staff

U.S. GOVERNMENT PRINTING OFFICE
81-986 WASHINGTON : 1988

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

H782-8

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LETTER OF TRANSMITTAL

COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES,
Washington, DC, March 24, 1988.

Hon. DAN ROSTENKOWSKI,
Chairman, Committee on Ways and Means,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: Upon your election as Chairman of the Committee on Ways and Means, you instructed the staff to prepare a document which would be of use to Members of the Committee when reviewing programs within the Committee's jurisdiction. A committee print entitled "Background Material and Data on Major Programs Within the Jurisdiction of the Committee on Ways and Means" (WMCP: 97-2) was published on March 10, 1981, and quickly became known as the "Green Book." As you know, the Green Book has been revised and updated annually.

On behalf of the staff, I am pleased to transmit to you and the other Members of the Committee on Ways and Means, the 1988 edition of the Green Book. The Green Book integrates a description of each program within the jurisdiction of the Committee with current data concerning the population served by the program, an analysis of interactions with other major programs, and historical information covering the program. It is a unique yearly compilation of information which Members of Congress appear to find extremely useful. In addition, it has come to the staff's attention that increasing numbers of analysts and institutions outside the legislative process have come to rely on the Green Book and look forward to its yearly publication.

The staff wishes to express its appreciation to the many individuals who contribute annually to the publication of the Green Book. The following organizations and individuals deserve special recognition for their efforts:

(1) The Congressional Research Service of the Library of Congress for assistance in preparing sections 1, 2, 3, 7, 8, and 9 of part 1; section 1 of part 2; section 2 of part 5; and appendices A, C, D, E, F, G, H, I, and L;

(2) The Congressional Budget Office for assistance in preparing appendices B, D, E, G, H, I, and L; and sections 1, 2, 3, and 4 of part 5, and for reviewing all drafts of the document;

(3) The Office of Research and Statistics of the Social Security Administration, and the Health Care Financing Administration, for updating the Social Security, Supplemental Security Income, Medicare, and Medicaid sections and other topics related to Social Security health programs and policies;

(4) The Office of the Actuary of the Social Security Administration for assistance in preparing section 3 of part 1;

(5) The Department of Labor for assistance in updating section 6 of part 1 and appendix F;

(6) The staff of the Railroad Retirement Board for updating sections 15 and 16 of part 2;

(7) The Office of Family Assistance and the Office of Child Support Enforcement of the Department of Health and Human Services for assistance in updating tables in the sections relating to the AFDC, child support enforcement, social services block grant, child welfare, and quality control programs;

(8) The staff of the Joint Committee on Taxation for preparing section 12 of part 1 and section 3 of part 5;

(9) Greg Duncan and Debbie Laren of the Institute for Social Research, University of Michigan, for special tabulations of the Panel Study of Income Dynamics which appear in the AFDC program section; and

(10) The Census Bureau for updating tables from the Survey of Income and Programs Participation in Appendix L.

Comments by Members of Congress and other interested persons regarding the format and content of this document are appreciated and will be reflected in future editions.

Sincerely,

ROBERT J. LEONARD,
Chief Counsel.

PREFACE

The staff of the Committee on Ways and Means, with assistance from many individuals at the Congressional Research Service, the Congressional Budget Office, the Social Security Administration, the Health Care Financing Administration, the Department of Health and Human Services, the Department of Labor, the Railroad Retirement Board, and the Joint Committee on Taxation, has prepared this document for the members of the committee to use in analyzing possible revisions to the programs under the committee's jurisdiction.

This document is divided into five distinct parts:

Part 1 describes programs within the jurisdiction of the committee. This part presents summary tables indicating the relative size and recent growth of the individual programs, and extensive information on program eligibility, payment, financing, participant characteristics, interactions with other programs, and history.

Also included in part 1 are 14 appendices which provide background data on topics indirectly related to these programs. The appendices include: a statistical history of the Social Security programs; health status, utilization, and expenditures of the elderly; national health expenditures and health insurance coverage; Medicare reimbursement to hospitals and physicians; data on unemployment, employment, and the labor force; demographic and economic characteristics of families with children and the elderly; poverty, income, and wealth statistics; income and population data by State; a description of quality control systems; and descriptions of major social programs not within the committee's jurisdiction.

Part 2 describes trust funds over which the committee has revenue jurisdiction. This part presents a brief legislative history of the trust funds, the current financing mechanism of the funds, and the financial status of the funds.

Part 3 describes Federal revenues and the U.S. tax system.

Part 4 provides a description of other matters within the jurisdiction of the committee, including public debt, the Pension Benefit Guaranty Corporation, and the Federal Financing Bank.

Part 5 presents budget tables, a description of the fiscal year 1989 administration budget proposals, and a description of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended. This part also includes two appendices which present excerpts from the Congressional Budget Act and the

Committee on Ways and Means' reports to the Budget Committee.

The material in this document has been assembled quickly in order that it be available to members of the committee for their use in connection with presently pending budget and program issues. Constructive comments regarding the format and content of this document are appreciated.

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PART 1

DESCRIPTION OF PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS PROVIDING BENEFITS OR SERVICES TO INDIVIDUALS

b.

Section 1. The Old-Age and Survivors Insurance Program (OASI)

The old-age and survivors insurance (OASI) program provides monthly benefits to retired workers and their dependents and to survivors of insured workers. Old-age retirement benefits were provided for retired workers by the original Social Security Act of 1935, and benefits for dependents and survivors were provided by the 1939 amendments. The disability insurance (DI) program, enacted in 1956, and the hospital insurance (HI) program, enacted in 1965, are closely related to the old-age and survivors insurance program. (These related programs are discussed in later sections.)

GENERAL

A worker builds protection under these programs through employment that is covered by the Social Security system. Coverage is generally compulsory. However, employees of State and local governments are covered on a voluntary group basis.[1] Currently, 93 percent of the Nation's work force is covered either voluntarily or mandatorily.

Contributions are made under the Federal Insurance Contributions Act (FICA, chapter 21 of the Internal Revenue Code). Contributions are based on wages and earnings up to the annual maximum taxable wage base ($45,000 in 1988). The employee contribution is withheld from wage and salary payments to employees and is matched by employers. Self-employed persons (SECA, chapter 2 of the Internal Revenue Code) pay contributions on their net earnings annually up to the same maximum as employees, but at a rate that is equal to the combined employee-employer tax rate. Until 1990, a general revenue credit is available to offset part of the SECA contribution.

Revenue from the OASI portion of the tax is credited automatically to the Old-Age and Survivors Insurance Trust Fund. In addition, the revenue derived from the taxation of a portion of Social Security retirement and survivors' benefits is credited to the OASI trust fund. The trust fund is the source of payment for: (1) monthly benefits when the worker retires or dies (including a financial interchange with the railroad retirement system), and (2) administrative expenses for the program.

BENEFITS

Summary

Monthly cash benefits under OASI are paid as a matter of earned right to workers who are insured for benefits and to their eligible dependents and survivors. Generally, benefit amounts paid both to the insured worker and to the insured worker's dependents or survivors are related to the past earnings of the insured worker. An individual may be entitled to benefits as a worker based on his own earnings history and also to benefits as a dependent of another worker. However, the amount of the benefit is adjusted so that, in effect, only the larger of the two benefits is paid.

---

[1] State and local coverage is voluntary for the OASI and DI programs. However, it became mandatory for HI purposes for persons hired by State or local governments on or after April 1, 1986.

In December 1987, there were 38.2 million beneficiaries in the OASI and DI programs who were in current-payment status. Monthly benefits paid out were $17.6 billion.

The following table summarizes various types of beneficiaries and average benefit amounts:

TABLE 1.—OASDI CASH BENEFITS IN CURRENT-PAYMENT STATUS, DECEMBER 1987

	Number (thousands)	Percent of beneficiary population	Average monthly benefit
Total monthly beneficiaries	38,190	100.0	$461
Retired workers	23,440	61.4	513
Wives and husbands of retired workers	3,090	8.1	264
Children of retired workers	440	1.2	216
Disabled workers	2,786	7.3	508
Wives and husbands of disabled workers	291	.8	135
Children of disabled workers	968	2.5	146
Widowed mothers and fathers	329	.9	353
Surviving children	1,836	4.8	352
Widows and widowers	4,879	12.8	468
Disabled widow(er)s	105	.3	334
Parents	8	.02	407
Special age-72	19	.05	145

Source: Office of Research and Statistics, Social Security Administration.

Description of major benefit types

Child's benefit. Under the OASI program, a monthly benefit is payable to an unmarried child or eligible grandchild of a retired worker or a deceased worker who was fully or currently insured at death if the child or grandchild is: (1) under age 18; (2) a full-time elementary or secondary student under age 19; (3) a dependent disabled person aged 18 or over whose disability began before age 22. A grandchild, including a great grandchild, is eligible for benefits on a grandparent's earnings record (or that of the spouse of such worker) if he is dependent on the grandparent for at least half his support and his parents are either disabled or deceased or, where a parent is alive, the grandparent is dead and the child has been adopted by the surviving grandparent.

Lump-sum death benefit. A lump-sum payment is payable upon the death of a fully or currently insured worker to the surviving spouse who was living with the deceased worker or was eligible to receive monthly cash survivor benefits upon the worker's death. If there is no eligible spouse, the lump-sum death payment is payable to any child of the deceased worker who is eligible to receive monthly cash benefits as a surviving child. If there is no surviving spouse and no children of the worker eligible for monthly benefits, then no one is eligible to receive the lump-sum death payment. The payment amount is $255.

Minimum benefit. The minimum benefit is the smallest benefit (before actuarial reduction or earnings test reduction) payable to a worker or his survivors/dependents. In 1977, the minimum benefit was frozen at $122 per month for all workers who became disabled after 1978 and all survivors of workers who died after 1978. The new frozen minimum of $122 was to have applied to all retired workers reaching age 62 in 1984 or later. However, legislation in 1981 eliminated the minimum benefit for all persons becoming eligible for benefits in January 1982 or later (except for certain members of religious orders who have taken a vow of poverty; such persons are exempt from the new law for ten years). These persons have their benefits computed under the regular benefit computation rules. Persons already eligible for benefits prior to January 1, 1982 are able to continue receiving the minimum benefit, which are subject to annual cost-of-living adjustments.

Mother's or father's benefit. A monthly benefit is payable to a widow (widower) or surviving divorced mother (father) if: (1) the deceased worker on whose account the benefit is paid was fully or currently insured at time of death and (2) the widow (widower) or surviving divorced mother (father) has one or more entitled children of the worker in his care. These payments continue until the youngest child being cared for reaches age 16.

Parent's benefit. This is a monthly benefit payable to a dependent parent, age 62 or over, of a deceased fully insured worker.

Retired-worker (old-age) benefit. This is a monthly benefit payable to a retired worker aged 62 or over who is fully insured.

"Special age-72" benefit. This is a monthly benefit payable to certain persons born before January 2, 1900, who do not have sufficient quarters of coverage to qualify for a retired-worker benefit. The benefit is payable only for months in which the individual is a resident of the 50 States or the District of Columbia and receives no public assistance cash payments or SSI payments. It is reduced by the amount of any government pension (except workers' compensation and veterans' service-connected compensation) that the individual is receiving or is eligible to receive. When husband and wife are both eligible for these benefits, a full benefit is paid to each spouse.

Special minimum benefit. This is a benefit that is not based on the worker's average monthly wage or average indexed monthly earnings, but instead on his/her length (years) of covered employment. It is designed to help those who worked in covered employment for many years but had low earnings. The amount of the special minimum is computed by multiplying the number of years of coverage in excess of 10 and up to 30 by $11.50 for monthly benefits payable in 1979, with automatic cost-of-living increases applicable to years 1979 and later. The number of years of coverage equals the number, not to exceed 14, obtained by dividing total creditable wages in 1937–50 by $900, plus the number of years after 1950 for which the worker is credited with at least 25 percent of the annual maximum taxable earnings. For this purpose for years after 1978, annual maximum taxable earnings are based on only the automatic adjustment provisions. The special minimum benefit is not subject to the delayed-retirement-credit provisions.

Spouse's benefit. This is a monthly benefit payable to a spouse or divorced spouse of a retired worker under one of the following conditions: (1) currently married spouse is aged 62 or older or is caring for one or more of the worker's entitled children who have not achieved age 16; or (2) divorced spouse is aged 62 or older, is not married, and the marriage to the worker had lasted 10 years before the divorce became final.

Widow's or widower's benefit. This is a monthly benefit payable to a widow(er) or surviving divorced spouse of a worker fully insured at the time of death if he or she is unmarried, or remarriage occurred after the widow(er)'s first eligibility for benefits; and (a) is aged 60 or older or (b) aged 50–59 and has been disabled throughout a waiting period of 5 consecutive calendar months that began no later than 7 years after the month the worker dies or after the end of her entitlement to benefits as a widowed mother.

BENEFIT ELIGIBILITY: INSURED STATUS

Benefits can only be paid to workers, their dependents or survivors if the worker is "insured" for these benefits. Insured status is measured in terms of "quarters of coverage."

TABLE 2.—AMOUNT OF COVERED EARNINGS NEEDED TO EARN ONE QUARTER OF COVERAGE SINCE 1977

1978	$250
1979	260
1980	290
1981	310
1982	340
1983	370
1984	390
1985	410
1986	440
1987	460
1988	470
1989	[1] 490
1990	[1] 520
1991	[1] 540

[1] 1987 OASDI Trustee's Report (II–B projection).

Prior to 1978, one quarter of coverage was earned for each calendar quarter in which a worker was paid $50 or more in wages for covered employment (except for agricultural labor). Since the beginning of 1978 the crediting of quarters of coverage has been on an annual rather than a quarterly basis. In 1978, a worker earned one quarter of coverage, up to a total of four, for each $250 of annual earnings reported from covered employment or self-employment. The amount of annual earnings needed for a quarter of coverage is subject to annual automatic increases, effective in January of each year, in proportion to increases in average wages in the economy. In 1988, the amount is $470 for workers.

For the purpose of the OASI program, there are two types of insured status: "fully insured" and "currently insured." Workers are fully insured for benefits for themselves and for their families if they have one quarter of coverage (earned at any time after 1936) for every four quarters elapsing after 1950, or the year of reaching age 21, if later, up to the year in which they reach age 62. Fully insured status is required for eligibility for all types of benefits except certain survivor benefits. A person must have at least six quarters of coverage to be fully insured. A person with 40 quarters of coverage is fully insured for life.

Workers are currently insured if they have six quarters of coverage during the thirteen calendar quarters ending with the quarter in which they died. Currently insured status by itself provides that the worker's surviving family members are eligible for child's, mother's, father's and lump-sum survivor benefits.

Table 3 indicates the type of insured status that is required for the various monthly benefit categories.

TABLE 3.—INSURED STATUS REQUIREMENTS FOR VARIOUS MAJOR BENEFIT CATEGORIES

Type of benefit	Basic eligibility requirements
Retirement	Fully insured.
Dependents:	
Wives, husbands	Worker entitled.
Mothers, fathers, children, grandchildren	Worker entitled.
Survivors:	
Dependent parents—age 62	Worker fully insured.
Widows, widowers	Worker fully insured.
Mothers, fathers, children	Worker fully or currently insured.
Lump-sum death	Worker fully or currently insured.

BENEFIT COMPUTATION

The amount of a monthly benefit award is determined by first computing an insured worker's average monthly wage (AMW) or—in the case of most workers who attain age 62, become disabled, or die after 1978—average indexed monthly earnings (AIME). The AMW is used in computing benefits under the old (pre-1979) benefit formula, and the AIME is used in computing benefits under the new (post-1978) benefit formula enacted in 1977. The AMW or AIME is linked (by a table or by a formula, respectively, in the law) to the monthly retirement benefit payable at that worker's normal retirement age. This amount is called the primary insurance amount (PIA). Benefits for dependents and survivors are calculated as a percentage of the insured worker's PIA. The calculated amounts may be subject to minimum levels, and all benefits are subject to maximum limits. Benefits payable to workers, spouses, widows, and widowers who choose to retire before their normal retirement age are subject to an actuarial reduction. Benefits payable to workers who choose to retire after their normal retirement age are subject to increase through the delayed retirement credit, as are the benefits payable to their spouses, widows, and widowers. The delayed retirement credit is 3 percent per year for workers age 65 before 1990. For workers age 65 after 1990, the delayed retirement credit will increase by one-half of 1 percent every other year until it reaches 8 percent in 2008.

The normal retirement age

The normal retirement age is the earliest age at which unreduced retirement benefits can be received. The normal retirement age is presently age 65, but will be gradually increased to age 67 beginning in 2000.[2] For persons reaching age 62 in 2000, the normal retirement age will be increased by 2 months—to age 65 and 2 months. In each succeeding year, the normal retirement age will be increased by 2 additional months until it reaches age 66 for persons attaining age 62 in 2005. The normal retirement age will then remain at age 66 for persons attaining age 62 through 2016. Beginning with persons attaining age 62 in 2017, the normal retirement age will again increase by 2 months each year, until it reaches age 67 for persons attaining age 62 in 2022 and later. (See table 4 for the exact schedule in increases in the normal retirement age.)

Average indexed monthly earnings (AIME)

The AIME is a dollar amount that represents the average monthly earnings, adjusted for change in average wages in the economy, that was received by the worker during a number of years of his covered employment. Indexing creates an earnings record that reflects the value of the individual's earnings relative to national average earnings in the indexing year. The indexing year is the second year before the year in which the worker attains age 62, becomes disabled, or dies. Earnings after the indexing year are counted at their nominal value.

There are four steps in the calculation of the AIME: (1) indexing the worker's earnings for each year after 1950 by dividing the worker's posted earnings for the year being indexed by the average wages of all workers in that same year and multiplying this result by the average earnings in the indexing year, (2) determining the number of computation years—the number of years after 1950 (or the year of attainment of age 21, if later) and up to the year worker attains age 62, becomes disabled, or dies, minus dropout years, generally 5 (minimum number of computation years is 2); (3) selecting the actual computation years, based on highest earnings, from any year after 1950; and (4) dividing the sum of earnings in the computation years by the total number of months in the computation years.

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[2] Changes in the normal retirement are a result of the Social Security Amendments of 1983 (P.L. 98-21).

TABLE 4.—INCREASES IN NORMAL RETIREMENT AGE FOR PERSONS REACHING AGE 62 IN EACH YEAR 1986 AND LATER

Year of birth	Year of attainment of age 62	Normal retirement age
1924	1986	65.
1925	1987	65.
1926	1988	65.
1927	1989	65.
1928	1990	65.
1929	1991	65.
1930	1992	65.
1931	1993	65.
1932	1994	65.
1933	1995	65.
1934	1996	65.
1935	1997	65.
1936	1998	65.
1937	1999	65.
1938	2000	65, 2 mo.
1939	2001	65, 4 mo.
1940	2002	65, 6 mo.
1941	2003	65, 8 mo.
1942	2004	65, 10 mo.
1943–54	2005–16	66
1955	2017	66, 2 mo.
1956	2018	66, 4 mo.
1957	2019	66, 6 mo.
1958	2020	66, 8 mo.
1959	2021	66, 10 mo.
1960 and later	2022 and later	67.

These computations are illustrated in table 5 for three different workers retiring in 1988 at age 62. The actual earnings for the three workers are shown in the first three columns. These are multiplied by the indexing factor (column 4) to arrive at indexed earnings (last 3 columns of table 5). The indexing factor for 1951 is average wages when an individual turned 60 ($17,322) divided by average wages for 1951 ($2,799). The lowest 5 years of indexed earnings may be dropped. For example, a lifelong full-time worker earning the minimum wage would be able to drop earnings in 1973, 1984, 1985, 1986, and 1987, and would have total indexed earnings of $291,681 (see table 5). Dividing this by the number of months in the computation period (32 years × 12 months = 384 months) results in an average indexed monthly earnings (AIME) of $759. The corresponding AIME's for the average and maximum earners are $1,445 and $2,311.

TABLE 5.—EARNINGS HISTORIES FOR HYPOTHETICAL WORKERS AGE 62 IN 1988

[Rounded to the nearest dollar]

Year	Nominal earnings			Indexing factor	Indexed earnings		
	Minimum [1]	Average [2]	Maximum [3]		Minimum	Average	Maximum
1951	1,560	2,799	3,600	6.1882	9,654	[4] 17,322	22,278
1952	1,560	2,973	3,600	5.8258	9,088	[4] 17,322	20,973
1953	1,560	3,139	3,600	5.5175	8,607	[4] 17,322	19,863
1954	1,560	3,156	3,600	5.4892	8,563	[4] 17,322	[4] 19,761
1955	1,560	3,301	4,200	5.2467	8,185	[4] 17,322	22,036
1956	1,993	3,532	4,200	4.9038	9,773	17,322	20,596
1957	2,080	3,642	4,200	4.7565	9,894	17,322	19,977
1958	2,080	3,674	4,200	4.7150	9,807	17,322	19,803
1959	2,080	3,856	4,800	4.4924	9,344	17,322	21,564
1960	2,080	4,007	4,800	4.3228	8,991	17,322	20,749
1961	2,184	4,087	4,800	4.2385	9,257	17,322	20,345
1962	2,392	4,291	4,800	4.0364	9,655	17,322	[4] 19,375
1963	2,461	4,397	4,800	3.9398	9,696	17,322	[4] 18,911
1964	2,600	4,576	4,800	3.7851	9,841	17,322	[4] 18,168
1965	2,600	4,659	4,800	3.7182	9,667	17,322	[4] 17,847
1966	2,600	4,938	6,600	3.5076	9,120	17,322	23,150
1967	2,886	5,213	6,600	3.3225	9,589	17,322	21,929
1968	3,293	5,572	7,800	3.1089	10,237	17,322	24,249
1969	3,328	5,894	7,800	2.9390	9,781	17,322	22,924
1970	3,328	6,186	7,800	2.8001	9,319	17,322	21,840
1971	3,328	6,497	7,800	2.6661	8,873	17,322	20,796
1972	3,328	7,134	9,000	2.4281	8,081	17,322	21,853
1973	3,328	7,580	10,800	2.2852	[4] 7,605	17,322	24,680
1974	3,883	8,031	13,200	2.1569	8,375	17,322	28,472
1975	4,368	8,631	14,100	2.0069	8,766	17,322	28,298
1976	4,784	9,226	15,300	1.8774	8,981	17,322	28,724
1977	4,784	9,779	16,500	1.7712	8,474	17,322	29,226
1978	5,512	10,556	17,700	1.6409	9,045	17,322	29,045
1979	6,032	11,479	22,900	1.5089	9,102	17,322	34,555
1980	6,448	12,513	25,900	1.3843	8,926	17,322	35,852
1981	6,968	13,773	29,700	1.2577	8,763	17,322	37,352
1982	6,968	14,531	32,400	1.1920	8,306	17,322	38,622
1983	6,968	15,239	35,700	1.1367	7,920	17,322	40,579
1984	6,968	16,135	37,800	1.0736	[4] 7,481	17,322	40,580
1985	6,968	16,823	39,600	1.0297	[4] 7,175	17,322	40,775
1986	6,968	17,322	42,000	1.0000	[4] 6,968	17,322	42,000
1987	6,968	[5] 18,136	43,800	1.0000	[4] 6,968	18,136	43,800

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[1] Worker with annual earnings equal to annualized Federal minimum wage.

[2] Worker with annual earnings equal to the SSA average wage index.

[3] Worker with annual earnings equal to the Social Security maximum taxable earnings.

[4] Dropout years.

[5] Estimate based on Alternative II–B assumptions in 1987 Trustees Report.

Average monthly wage (AMW)

The AMW, which is used in computing benefits under the old pre-1979 benefit formula, is computed by: (1) determining the number of computation years—the number of years after 1950 (or the year of attainment of age 21, if later) and up to the year the worker attains age 62 (age 65 for men born before January 2, 1911, and the later of age 62 or the year 1975 for men born after January 1, 1911), onset of disability or death, minus dropout years, generally 5 (minimum number of computation years is 2); (2) selecting the actual computation years, based on highest nonindexed earnings, for any year after 1950; and (3) dividing the sum of nonindexed earnings in the computation years by the total number of months in the computation years.

Primary insurance amount (PIA)

The monthly benefit amount payable to a retired worker who begins to receive benefits at his normal retirement age is his PIA truncated to the next lower dollar. The PIA is used as a base for computing all benefits which are payable on the basis of that worker's earnings record.

The method of determining the PIA depends on whether an AIME or an AMW was computed for the worker. (This, of course, is determined on the basis of the worker's date of birth.) If an AMW has been computed for the worker, the PIA is determined through reference to benefit tables which are updated and published annually. Under a transitional guarantee provision of the 1977 amendments (which is applicable only to workers who attain age 62 in 1979–83), the PIA is determined on the basis of the frozen 1978 benefit table if it is higher than under the AIME method.

In cases where an AIME has been computed, the PIA is determined by applying the "primary benefit formula" to the AIME. For a worker reaching age 62 in 1988, the PIA equals 90 percent of the first $319 of AIME, 32 percent of the next $1,603 of AIME, and 15 percent of the AIME above $1,922. Applying this formula to the AIME's of the three example workers results in PIA's of $427.90 for the minimum-wage worker, $647.40 for the average-wage worker, and $858.40 for the maximum-wage worker. The numbers $319 and $1,922 are often referred to as "bend points." These are adjusted each year by change in average wages.

After the year of initial eligibility (age 62 for retired worker benefits), the PIA is increased each year for the increase in the Consumer Price Index (CPI). Thus, the PIA's of $427.90, $647.40, and $858.40 would be in effect for January through November 1988, and will be increased by the cost-of-living adjustment that will increase the December 1988 benefits under current law.

BENEFIT AMOUNTS

The monthly benefit amount payable to a retired worker who begins to receive benefits at this normal retirement age is his PIA truncated to the next lower dollar.

Workers attaining age 62 before 2000 (the year in which the retirement age begins to increase) who retire before age 65 will receive a benefit with an actuarial reduction. Retirement after age 65 results in an actuarial increase in the benefit payable.

After the year 2000, the minimum age of eligibility for reduced benefits will remain unchanged at age 62 (age 60 for widows and widowers). However, there will be corresponding increases in the amount of reduction for early retirement. The amount of reduction will be ⁵⁄₉ of 1 percent for each of the first 36 months of early retirement (as under present law), and ⁵⁄₁₂ of 1 percent for each month in excess of 36. Thus, for persons attaining age 62 during 2005–16, for whom the normal retirement age will be 66, the reduced benefit payable at age 62 will be 75 percent of the PIA. For persons attaining age 62 in 2022 and later, for whom the normal retirement age will be 67, the reduced benefit payable at age 62 will be 70 percent of the PIA. (See table 6.) There will be no increase in the maximum reduction for widow(er)s.

TABLE 6.—SCHEDULE OF BENEFITS, AS A PERCENTAGE OF PIA, PAYABLE AT SELECTED AGES, FOR PERSONS REACHING AGE 62 IN EACH YEAR 1986 AND LATER

Year of attainment of age 62	Benefit, as a percentage of PIA, if retiring at age—		
	62	65	67
1986	80	100	106
1987	80	100	107
1988	80	100	107
1989	80	100	108
1990	80	100	108
1991	80	100	109
1992	80	100	109
1993	80	100	110
1994	80	100	110
1995	80	100	111
1996	80	100	111
1997	80	100	112
1998	80	100	112
1999	80	100	113
2000	79⅙	98⁸⁄₉	111¹¹⁄₁₂
2001	78⅓	97⁷⁄₉	111⅔
2002	77½	96⅔	110½
2003	76⅔	95⁵⁄₉	110
2004	75⅚	94⁴⁄₉	108¾
2005–16	75	93⅓	108
2017	74⅙	92²⁄₉	106⅔
2018	73⅓	91⅑	105⅓
2019	72½	90	104
2020	71⅔	88⁸⁄₉	102⅔
2021	70⅚	87⁷⁄₉	101½
2022 and later	70	86⅔	100

Auxiliary benefit amounts are also based on the worker's PIA. Table 7 lists major types of benefits with the percent of the insured worker's PIA which is paid.

TABLE 7.—PERCENTAGE OF PRIMARY INSURANCE AMOUNT (PIA) PAID FOR DEPENDENT'S AND SURVIVOR'S BENEFITS

Type of monthly benefit	Percent of PIA
Dependents: [1]	
Wives, husbands—age 65	[3] 50.0
Mothers, fathers, children, grandchildren	50.0
Survivors: [1]	
Widows, widowers—age 65 [2]	[3] 100.0
Dependent parent—age 62	82.5
Widows, widowers, disabled—age 50	71.5
Mothers, fathers, children	75.0

[1] Subject to maximum family benefit limitation.

[2] Subject to general limitation that survivor cannot get a higher benefit than deceased worker would be getting if alive.

[3] These percentages decrease as the normal retirement age increases beginning in the year 2000.

REPLACEMENT RATES

Frequently Social Security benefits are discussed in terms of how much of a person's preretirement earnings the benefits represent. Benefits expressed as a percent of earnings are called replacement rates. The following table shows replacement rates based on the PIAs of hypothetical workers who retired at age 65 after full-time careers with steady earnings equal to: (1) the Federal minimum wage, (2) average earnings in the economy (as recorded through the Social Security earning index), and (3) the maximum earnings taxable each year for FICA and SECA tax purposes. A more complete table is included in appendix A.

TABLE 8.—SOCIAL SECURITY REPLACEMENT RATES, 1940–2040

[In percent]

Calendar year	Replacement rates[1]		
	Minimum earner	Average earner	Maximum earner
1940	39.8	26.3	16.5
1950	42.8	19.7	21.2
1960	45.0	33.3	29.8
1965	40.0	31.4	32.9
1970	42.7	34.3	29.2
1975	59.5	42.3	30.1
1976	57.9	43.7	32.1
1977	57.2	44.8	33.5
1978	62.7	46.7	34.7
1979	60.4	48.1	36.1
1980	64.0	51.1	32.5
1981	68.5	54.4	33.4
1982	63.8	48.7	28.6
1983	63.7	45.8	26.4
1984	62.4	42.9	23.7
1985	63.8	40.9	22.8
1986	65.7	41.2	23.1
1987	67.6	41.3	22.6
1988	71.2	41.8	23.1
1989	72.7	42.7	24.2
1990	74.2	43.6	25.1
2000	68.5	41.3	25.3
2010	64.8	41.3	27.1
2020	62.0	41.3	27.7
2030	59.9	41.3	27.7
2040	59.8	41.3	27.6

[1] Sum of monthly PIAs in year of entitlement expressed as percent of earnings in year prior to entitlement. Projections for 1987 and later are based on the Intermediate II–B assumptions of the 1987 OASDI Trustees' Report.

Source: Office of the Actuary, Social Security Administration.

BENEFIT REDUCTION AND INCREASE

Social Security benefits may be reduced, withheld or increased for several reasons, chiefly on account of early retirement, delayed retirement, and on account of earnings in excess of the exempt amount provided in the law ($8,400 in 1988 for beneficiaries between age 65 and 70). In addition, there is an overall limit on the total amount of benefits which can be paid at one time on the basis of any one earnings record.

Actuarial reduction. This is the reduction in monthly benefit amount payable: (a) on entitlement at ages 62–64 if the beneficiary is a retired worker, a spouse of a retired or disabled worker (with entitlement not dependent on having a child beneficiary in his/her care), or a divorced spouse; (b) on entitlement at age 60–64 if the beneficiary is a widow, widower, or a surviving divorced spouse; or (c) on entitlement, in case of disability, at ages 50–59 if the beneficiary is a widow, widower, or surviving divorced spouse.

At the time of award, the following reductions in benefit amount are made for:

A retired-worker beneficiary—$\frac{5}{9}$ of 1 percent for each month of entitlement before age 65 (maximum reduction of 20 percent);

A wife or husband beneficiary—$\frac{25}{36}$ of 1 percent for each month of entitlement before age 65 (maximum reduction of 25 percent);

A widow including surviving divorced spouse—$\frac{19}{40}$ of 1 percent for each month of entitlement between age 60 (maximum reduction of 28.5 percent) and age 65. Disabled widow(er)s ages 50 to 59 receive 71.5 percent of the PIA.

The benefit continues to be paid at a reduced rate even after age 65, except that the reduced rate is refigured at age 65 for all beneficiaries and also at age 62 for a widow, widower, and a surviving divorced spouse to omit months for which the reduced benefits was not paid and to take into account any additional earnings. Data on benefit awards to retired workers in 1987 indicates that 74 percent of all such awards were actuarially reduced benefits (70 percent for men, 79 percent for women).

Delayed retirement credit. A credit due a worker for delayed retirement after attaining age 65 for each month the worker: (1) was fully insured, (2) had attained age 65 but was not yet age 70, and (3) did not receive benefits because the worker had not filed an application or was working. Each monthly credit serves as a basis for increasing the monthly benefit (unless the benefit is based on a special minimum PIA) by $\frac{1}{12}$ of 1 percent for workers who attained age 62 before 1979 and by $\frac{1}{4}$ of 1 percent for workers attaining age 62 from 1978 through 1986. The increase is applicable to the worker's monthly benefits amount but not to his PIA. Hence, auxiliary benefits are generally not affected. The exception is that a surviving spouse (including divorced) receiving widow(er)'s benefits is entitled, for months after May 1978 to the same increase that had been applied to the benefit of the deceased worker or for which the worker was eligible for at the time of death.

As a result of the Social Security Amendments of 1983, beginning with workers who attain age 65 in 1990, (i.e., age 62 in 1987) the increment for delaying retirement past the normal retirement age will increase by $\frac{1}{2}$ of 1 percent every second year until reaching 8 percent per year of delayed retirement for workers attaining age 65 after 2007.

Maximum family benefit. The maximum monthly amount that can be paid on a worker's earnings record varies with his PIA. For benefits payable on the earnings records of retired and deceased workers, the maximum varies between 150 and 188 percent of the PIA. No more than the established maximum can be paid to a family regardless of the number of beneficiaries entitled on that earnings record. The family maximum is computed by adding fixed percentages of dollar amounts which are part of the PIA. For the family of a worker who becomes age 62 or dies in 1988, the total amount of benefits payable to them will be:

150 percent of the first $407 PIA, plus;
272 percent of PIA from $407 through $588, plus;

134 percent of PIA from $588 through $767, plus;
175 percent of PIA over $767.

The dollar amounts in this benefit formula (i.e. the "bend points") are adjusted annually by the same index used to update the bend points in the primary benefit formula.

Whenever the total of the individual monthly benefits payable to all the beneficiaries entitled on one earning record exceeds the maximum, each dependent's or survivor's benefit is proportionately reduced to bring the total within the maximum.

In computing the total of the individual monthly benefits for entitlements based on a single earnings record, a benefit payable to a divorced spouse or to a surviving divorced wife is not included.

Retirement test. The retirement test is a provision in the law that reduces benefits for recipients who earn income from work above a certain amount.

The test has been modified many times over the years. Currently, the law provides that beneficiaries under age 65 may earn up to $6,120 a year in wages or self-employment income without their benefits being affected. Beneficiaries age 65-69 can earn up to $8,400 a year. For earnings in excess of these amounts, $1 of benefits is lost for each $2 of earnings. The exempt amounts are adjusted each year to rise in proportion to average wages in the economy. The test does not apply to beneficiaries age 70 and over (they receive full benefits regardless of the level of their earnings). In addition, in the first year of entitlement (and last year for dependent beneficiaries), the so-called "grace year," a beneficiary may receive benefits for any month in which his or her benefits do not exceed one-twelfth of the annual exempt amount, regardless of annual earnings. For the self-employed, excess earnings cannot be charged to any month in which the individual does not perform "substantial services" in his or her trade or business.

Examples:

1. John—Age 63 with $4,000 in annual benefits before the retirement test is applied:

Earnings in 1988	$7,120
Exempt amount for under age 65	6,120
Excess over exempt amount	1,000
Benefit reduction = 50 percent of excess	500
Benefits John will receive in 1988	3,500

2. Ida—Age 67 with $4,000 in annual benefits before the retirement test is applied:

Earnings in 1988	$9,000
Exempt amount for 65 and older	8,400
Excess over exempt amount	600
Benefit reduction = 50 percent of excess	300
Benefits Ida will receive in 1988	3,700

Beginning in 1990, a more generous formula for beneficiaries aged 65-69 will go into effect. They will lose $1 in benefits for each $3 of earnings above the exempt amount.

The test does not apply to pensions, rents, dividends, interest, and other types of "unearned" income. These forms of income were exempted in order to encourage savings for retirement as supplements to Social Security.

The retirement test was part of the original plan that led to Social Security: The 1935 report of the Committee on Economic Security appointed by President Franklin D. Roosevelt recommended that no benefits be paid before a person had "retired from gainful employment." Initially, the Social Security Act provided that benefits would not be paid for any month in which the individual had received "wages with respect to regular employment." What constituted "regular employment" was unspecified, and it was unclear whether the term "wages" referred only to those from Social Security-covered employment, but it was apparent that the intent was to withhold payment of benefits to recipients if they worked at all.

Before any benefits were payable under the program and the provision could go into effect, Congress modified the test in the Social Security Amendments of 1939. Benefits would not be paid for any month in which wages from covered employment were $15 or more, even if the wages exceeded $15 only slightly and the benefits lost were greater than the wages earned. This arrangement prevailed until 1950. Among the major provisions of the 1950 Amendments was Social Security coverage of the bulk of nonfarm self-employed workers. It was claimed that many self-employed people never retired and therefore would never receive benefits. As a result, the 1950 Act exempted persons age 75 and over from the test. In addition, in the first of many actions to increase the amount of earnings permitted, allowable monthly income from wages was increased from $14.99 to $50. The self-employed were subject to an annual (rather than a monthly) test of $600 a year before their monthly benefits would be withheld.

Over the years, the earnings limits, the age limits, and test formulae have been changed many times. The 1954 Amendments lowered the age limit to 72, and established a uniform annual earnings test for both wage earners and the self-employed (instead of the two separate tests previously provided). Under the new annual test, 1 month's benefits would be withheld for each $80 of earnings in excess of $1,200, and all types of earnings, not just covered earnings, would be taken into account. However, regardless of yearly earnings, benefits were payable in any month in which the individual did not earn more than $80 in wages or render "substantial services" in self-employment.

The 1960 Amendments introduced a two-tiered limit on earnings and eliminated the withholding of a full month's benefits once the limit was reached. Instead, $1 in benefits would be withheld for each $2 in earnings from $1,200 to $1,500, and $1 in benefits would be withheld for each $1 in earnings above $1,500. The $1 for $1 reduction had been heavily criticized for completely discouraging work, especially because the dollar of earnings was subject to the income tax, whereas the dollar lost in benefits was not.

In 1972, the $1 for $2 reduction was made applicable for all earnings above the exempt amount. Also, the 1972 Amendments provided that, beginning in 1975, the exempt amounts would be "indexed" to rise at the same rate as wage growth. To compensate workers who did not receive benefits between ages 65 and 72, including those who did not because of the retirement test, the Amendments provided a "delayed retirement credit" (DRC).

In the consideration of major Social Security legislation in 1977, there was considerable pressure to eliminate the retirement test for persons over age 65. As a compromise, the limits on earnings were raised for persons age 65 and older, and since then two different exempt amounts have applied for those under and over age 65. The 1977 Amendments also lowered from 72 to 70 the age at which the test would no longer apply, to be effective in 1982 (subsequent legislation postponed the effective date to 1983). In response to criticism that it discriminated in favor of workers who had substantial but irregular employment (e.g., teachers), Congress also eliminated the monthly test except for the first year of retirement.

Eliminating the monthly test raised unexpected problems with regard to certain dependent benefits and for retired persons who received commissions from preretirement sales or other related forms of delayed compensation. Student survivor beneficiaries, for instance, who became ineligible for benefits during the course of a year because they graduated from college, had to repay the benefits paid to them in the early part of the year because their subsequent earnings exceeded the yearly exempt amounts, and retired insurance agents would lose benefits in years after they retired because of commissions they received from preretirement sales. In 1980, these problems were addressed by legislation extending the "monthly test" to the year a dependent beneficiary becomes ineligible for benefits and by changing the treatment of various forms of earnings received after entitlement.

As part of major legislation restoring financial integrity to Social Security in 1983, Congress made two liberalizations, to take place in the future, affecting persons who continue to work after attaining retirement age. The first provided that beginning in 1990 beneficiaries who have attained the "full retirement age" (currently age 65) will lose only $1 in benefits for each $3 in earnings above the exempt amount. The second increased the delayed retirement credit (DRC). Currently, the DRC is equal to ¼ of 1 percent for each month (3 percent a year) beyond the full retirement age that a person does not receive benefits. Under the 1983 provision, the DRC will increase gradually to ⅔ percent a month over the period 1990 to 2009 (8 percent a year).

As a result of a legislative change in the Deficit Reduction Act of 1984, the Social Security Administration has begun to request earlier reports of earnings from beneficiaries who are most likely to have earnings in excess of the exempt amount. These beneficiaries may thus have their benefits ceased in the actual year of excess earnings, rather than receiving overpayments which must then be recouped later.

TABLE 9—RETIREMENT TEST EXEMPT AMOUNTS

Year	Under age 65	Age 65 through 69
1975	$2,520	$2,520
1976	2,760	2,760
1977	3,000	3,000
1978	3,240	4,000
1979	3,480	4,500
1980	3,720	5,000
1981	4,080	5,500
1982	4,440	6,000
1983	4,920	6,600
1984	5,160	6,960
1985	5,400	7,320
1986	5,760	7,800
1987	6,000	8,160
1988	6,120	8,400
1989	[1] 6,480	[1] 8,760
1990	[1] 6,840	[1] 9,240
1991	[1] 7,200	[1] 9,720
1992	[1] 7,560	[1] 10,320

[1] Estimated.

Source: 1987 OASDI Trustees Report, alternative II–B.

Note.—Before January 1983, the retirement test applied to beneficiaries under age 72 (instead of 70).

Withholding. This is the suspension of benefit payments until the conditions causing deductions are known to have ended. Reasons for withholding benefits include: (1) earnings by a beneficiary (or any dependent drawing benefits on his earnings record) under age 70 from either covered or noncovered employment which exceeds the annual allowable amount (this is known as the "retirement test"); (2) failure of a wife under age 62 or mother or father beneficiary to have an entitled child in her care; (3) for special age-72 beneficiaries, receipt of public assistance or supplemental security income (SSI) payments or government pensions; (4) the payee is not determined; and (5) administrative reasons.

Some of the administrative reasons for withholding benefits are: (a) refusal of beneficiary to accept checks for personal reasons; (b) beneficiary's residence in certain foreign countries; and (c) under certain conditions, an alien beneficiary's residence outside the United States for more than 6 full consecutive calendar months.

Suspension of monthly benefit payments does not affect eligibility for hospital insurance benefits.

BENEFITS FOR RECIPIENTS OF PENSIONS FROM NONCOVERED EMPLOYMENT

The public pension offset.—Social Security benefits payable to spouses of retired, disabled, or deceased workers are generally reduced to take account of any public pension the spouse receives as a result of work in a government job not covered by Social Security. The amount of the reduction is equal to two-thirds of the government pension. The offset does not apply to workers whose government job is covered by Social Security on the last day of the person's employment.

Generally, Federal workers hired before 1984 are part of the Civil Service Retirement System (CSRS) and are not covered by Social Security. Federal workers hired after 1983 are covered by the Federal Employee's Retirement System Act of 1986 (FERS), which includes coverage by Social Security. The FERS law provided employees covered by the CSRS the opportunity from July 1, 1987, to December 31, 1987, to make a one-time election to join FERS and thereby obtain Social Security coverage. Thus, a CSRS employee who switched to FERS during this period immediately became exempt from the government pension offset.

The "windfall" benefit.—Under the so-called "windfall" benefit provision of the Social Security Amendments of 1983, Social Security benefits are generally reduced for workers who also have pensions from work that was not covered by Social Security (e.g., work under the Federal Civil Service Retirement System). Under the regular, weighted benefit formula, benefits are determined by applying a percentage to average indexed monthly earnings. In 1988, benefits equal 90 percent of the first $319 of average indexed monthly earnings, 32 percent of earnings from $319 to $1,922, and 15 percent of earnings above $1,922. The formula applicable to those with pensions from noncovered employment substitutes 40 percent for the 90 percent factor in the first bracket. (The second and third factors remain the same.) The resulting reduction in the worker's Social Security benefit is limited to one-half the amount of the noncovered pension. The new law is being phased in over a 5-year period beginning with those first eligible for Social Security benefits and noncovered pensions in 1986.

Workers who have 30 years or more of substantial Social Security coverage are fully exempt from this treatment. For workers who have 26–29 years of coverage, the percentage in the first bracket in the formula increases by 10 percentage points for each year over 25, as illustrated below:

	Percent
Years of Social Security coverage:	
First factor in formula	
25 or less	40
26	50
27	60
28	70
29	80
30 or more	90

AUTOMATIC BENEFIT ADJUSTMENTS

Benefit increases for Social Security and SSI recipients are based on increases in the cost of living as measured by the Bureau of Labor Statistics' Consumer Price Index (CPI). As a result of a provision contained in the Omnibus Budget Reconciliation Act of 1986, it is no longer necessary for the rise in the CPI to exceed 3 percent in order to trigger the annual cost-of-living adjustment (COLA). A COLA will now be provided in any year in which there is a measurable (0.1 percent) increase in consumer prices. If there was a year of price deflation and no COLA was provided, then a 2-year change in the CPI of at least 0.1 percent is needed before a COLA is provided.

Prior to 1984, the change in the CPI was measured from the first calendar quarter of the base year to the first calendar quarter of the current year. However, the benefit increases in 1984 and later years are based on the CPI increase from the third quarter of the base year through the third quarter of the year in which the benefit increase becomes effective. In addition, benefit increases beginning with the January 1986 check *are* based upon a price index in which the housing component is measured on a rental equivalence basis.

If the assets of the combined OASI and DI trust funds are below a certain reserve ratio (15 percent for 1984 through 1988, and 20 thereafter) and wages increase at a rate lower than inflation, the automatic benefit increase will be based on wage growth rather than inflation.

The Secretary of Health and Human Services (HHS) is required by law to publish the amount of the increase in the Federal Register within 45 days after the close of the measuring period. The benefit increase is effective in December and first appears in January benefit checks, i.e., 3 months after the close of the measuring period. (Prior to 1983 the benefit adjustment was effective in June and payable in July.)

Since a benefit increase was effective in 1986, that year became the base for the 1987 benefit increase. The CPI for the third quarter of 1986 was 323.7. This was the arithmetical average of the CPI for July, August and September, 1986.

Month in 1986:	CPI
July	322.9
August	323.4
September	324.9
Total	971.2

The average CPI for the 3rd quarter of 1986 is thus:

$$971.2/3=323.7$$

The CPI for the third quarter of 1987 was 337.4. This was the arithmetical average of the CPI for July, August and September, 1987.

Month in 1987:	CPI
July	335.6
August	337.4
September	339.1
Total	1,012.1

The average CPI for the 3rd quarter of 1987 is thus:

$$1{,}012.1/3=337.4$$

The percentage increase in the CPI from the third quarter of 1986 to the third quarter of 1987 is:

$$(337.4-323.7)/323.7=4.2 \text{ percent}$$

Thus, the benefit increase for December 1987 was 4.2 percent (and was reflected in the January 1988 checks).

The benefit increase is always rounded to the nearest 0.1 percent. It applies to all types of beneficiaries.

TABLE 10.—HISTORICAL COMPARISON OF AVERAGE WAGE INCREASES TO BENEFIT INCREASES AND CHANGES IN CPI, 1965–1987

[In percent]

	Increase in wages over prior year [1]	Increase in CPI over prior year [2]	Increase in benefits over prior year [3]
1965	1.8	1.7	7.0
1966	6.0	2.9	0
1967	5.6	2.9	0
1968	6.9	4.2	13.0
1969	5.8	5.4	0
1970	5.0	5.9	15.0
1971	5.0	4.3	10.0
1972	9.8	3.3	20.0
1973	6.3	6.2	0
1974	5.9	11.0	11.0
1975	7.5	9.1	8.0
1976	6.9	5.7	6.4
1977	6.0	6.5	5.9
1978	7.9	7.6	6.5
1979	8.7	11.4	9.9
1980	9.0	13.5	14.3
1981	10.1	10.2	11.2
1982	5.5	6.0	7.4
1983	4.9	3.0	[4] 3.5
1984	5.9	3.4	3.5
1985	4.3	3.5	3.1
1986	3.0	1.5	1.3
1987	[5] 3.0	3.6	[6] 4.2

[1] Average annual earnings series used to index earnings records.

[2] Increase in annual average CPI–W.

[3] Legislated benefit increases through 1975 and increases based on CPI thereafter.

[4] As a result of the Social Security Amendments of 1983, COLA's are provided on a calendar year basis, with the benefit increase payable in January rather than July. The July 1983 COLA was delayed to January 1984. This delay and a change in the computation period led to 6 months of 1983 not being accounted for in any COLA increase.

[5] Preliminary.

[6] Effective December 1987, payable January 1988.

Source: Office of Research and Statistics, Social Security Administration.

TAXATION OF SOCIAL SECURITY (OASDI) BENEFITS FOR HIGHER-INCOME PERSONS

Beginning in 1984, as much as one-half of OASDI benefits (and railroad retirement tier 1 benefits) are included in taxable income for taxpayers with incomes above certain base amounts. The sum of a taxpayer's (1) adjusted gross income, (2) tax-free interest income and (3) one-half of OASDI benefits is compared to a base amount of $25,000 for a single taxpayer, or $32,000 for a married couple filing a joint tax return. If the sum exceeds the base amount, the amount of benefits to be included in taxable income is the lesser of:

(a) one-half of the excess of such sum over the base amount, or

(b) one-half of the amount of benefits received.

The following table contains several examples which illustrate the taxation of Social Security benefits.

EXAMPLES

		A	B	C	D	E
(1)	Type of taxpayer	Single	Single	Couple	Couple	Couple
(2)	Adjusted gross income	16,000	23,000	24,000	28,000	50,000
(3)	Tax-free interest income	0	0	0	3,000	2,000
(4)	Social Security	$4,000	$8,000	$3,000	$6,000	$10,000
(5)	Sum of lines (2) plus (3) plus one-half of (4)	18,000	27,000	25,500	34,000	57,000
(6)	Base amount	25,000	25,000	32,000	32,000	32,000
(7)	Excess amount (line (5) minus (6))	−7,000	2,000	−6,500	2,000	25,000
(8)	Amount of Social Security which is taxed. If line (7) is positive, lesser of one-half of lines (7) or (4). If line (7) is zero or negative, enter 0	0	1,000	0	1,000	5,000

The proceeds from the taxation of Social Security benefits are credited to the OASDI trust funds (see table 11).

For calendar year 1984, there was an estimated 2.6 million tax returns with some Social Security benefits in adjusted gross income. (Also see table 21.)

TABLE 11.—TAXATION OF SOCIAL SECURITY BENEFITS; LIABILITIES INCURRED AS A PERCENT OF TOTAL BENEFIT PAYMENTS

[Dollars in millions]

Fiscal year	Income tax liabilities incurred from the taxation of OASDI benefits	Total OASDI benefit payments	Income tax liabilities as a percent of total OASDI benefit payments
Past experience:			
1984	$2,275	$173,603	1.3
1985	3,368	183,959	1.8
1986	3,558	193,869	1.8
Projected:			
1987	3,499	202,584	1.7
1988	3,690	214,054	1.7
1989	4,135	228,593	1.8
1990	4,744	244,859	1.9
1991	5,319	262,641	2.0

Source: Derived from data contained in the 1987 OASDI Trustees' Report, Intermediate II–B assumptions.

LEGISLATIVE CHANGES MADE IN THE 97TH CONGRESS

The 97th Congress made numerous changes in the OASDI program. The major changes were included in the Omnibus Budget Reconciliation Act (Public Law 97-35). Table 12 lists these changes and contains the most recent Congressional Budget Office estimates of their budgetary impact.

TABLE 12.—CONGRESSIONAL BUDGET OFFICE ESTIMATES FOR LEGISLATIVE CHANGES MADE IN OASDI DURING 1981 (JANUARY 1982 ESTIMATES), FISCAL YEARS 1982–84

[In millions of dollars]

	Fiscal year—		
	1982	1983	1984
Elimination of minimum benefit for future beneficiaries	−81	−180	−210
Elimination of benefits for postsecondary students	−567	−1,580	−2,033
Restrictions on payment of lump-sum death benefits	−200	−210	−215
Modification of month of initial entitlement for certain workers and their dependents	−190	−220	−240
Temporary extension of earnings limitation to include all persons aged less than 72	−380	−120	0
Termination of mother's and father's benefits when youngest child attains age 16	−30	−88	−496
Modification of rounding rules	−79	−272	−314
Cost reimbursement for provision of earnings information	−1	−2	−5
Revision of reimbursements for vocational rehabilitation services	−87	−86	−73

TABLE 12.—CONGRESSIONAL BUDGET OFFICE ESTIMATES FOR LEGISLATIVE CHANGES MADE IN OASDI DURING 1981 (JANUARY 1982 ESTIMATES), FISCAL YEARS 1982–84—Continued

[In millions of dollars]

	Fiscal year—		
	1982	1983	1984
Modify worker's compensation offset to: (1) Apply offset to certain other public disability benefits-megacap; (2) apply offset to benefits of workers aged 62 to 64; and (3) begin offset in first month of dual benefit payment	−87	−122	−156
Extension of coverage to first 6 months of sick pay (revenue increase)	−534	−762	−828
Total OASDI	−2,236	−3,642	−4,570

LEGISLATIVE CHANGES MADE IN THE 98TH CONGRESS

The 98th Congress made extensive changes in the OASDI programs in the Social Security Amendments of 1983 (Public Law 98–21), enacted to restore the financial status of the Social Security trust funds. Table 13 outlines the estimated outlay and revenues effects of the 1983 amendments under the alternative II-B assumptions of the 1983 Trustees' report. At the time, it was estimated that in the period 1983 through 1989 the OASDI and HI trust funds would receive $166.2 billion and $33.6 billion in additional financing, respectively.

TABLE 13.—ESTIMATED AMOUNTS OF CHANGES IN OASDI TAX INCOME, GENERAL FUND TRANSFERS, AND BENEFIT PAYMENTS RESULTING FROM THE PROVISIONS IN PUBLIC LAW 98–21, BASED ON 1983 ALTERNATIVE II–B ASSUMPTIONS, CALENDAR YEARS 1983–89

[In billions of dollars]

Provision	Calendar year—							Total, 1983–89
	1983	1984	1985	1986	1987	1988	1989	
Increase tax rate on covered wages and salaries		8.6	0.3			14.5	16.0	39.4
Increase tax rate on covered self-employment earnings		1.1	3.1	3.0	3.2	3.7	4.4	18.5
Cover all Federal elected officials and political appointees		(1)	(1)	(1)	(1)	(1)	(1)	(.1)
Cover new Federal employees		.2	.7	1.2	1.8	2.4	3.1	9.3
Cover all nonprofit employees		1.3	1.5	1.8	2.1	2.6	3.0	12.4
Total for new coverage		1.5	2.2	3.0	3.9	5.0	6.1	21.8
Prohibit State and local government terminations		.1	2.	.4	6.	8.	1.1	3.2

TABLE 13.—ESTIMATED AMOUNTS OF CHANGES IN OASDI TAX INCOME, GENERAL FUND TRANSFERS, AND BENEFIT PAYMENTS RESULTING FROM THE PROVISIONS IN PUBLIC LAW 98-21, BASED ON 1983 ALTERNATIVE II-B ASSUMPTIONS, CALENDAR YEARS 1983-89—Continued

[In billions of dollars]

Provision	Calendar year—							Total, 1983-89
	1983	1984	1985	1986	1987	1988	1989	
Accelerate collection of State and local taxes		.6	(1)	(1)	.1	.1	.1	1.0
Modify general fund financing basis for non-contributory military service credits	18.4	−.4	−.4	−.3	−.4	−.4	−.4	16.1
Provide reimbursements from general fund for unnegotiated checks	1.3	.1	.1	.1	.1	.1	.1	1.6
Delay benefit increases 6 months	3.2	5.2	5.4	5.5	6.2	6.7	7.3	39.4
Continue benefits on remarriage		(2)	(2)	(2)	(2)	(2)	(2)	−.1
Modify indexing of deferred survivors' benefits			(2)	(2)	(2)	(2)	(2)	(2)
Raised disabled widow(er)'s benefits to 71.5 percent of PIA		−.2	−.2	−.2	−.2	−.3	−.3	−1.4
Pay divorced spouses whether or not worker has retired			(2)	(2)	(2)	(2)	(2)	−.1
Replace 90-percent factor in benefit formula with variable percentage, for individuals receiving pensions from noncovered employment				(3)	(3)	(3)	.1	.1
Offset spouses benefits by up to two-thirds of noncovered Government pension	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)
Expand use of death certificates to stop benefits	(3)	(3)	(3)	(3)	(3)	(3)	(3)	.1
Impose 5-year residency requirement for certain aliens			(3)	(3)	(3)	(3)	(3)	.1
Tax one-half of benefits for high income beneficiaries		2.6	3.2	3.9	4.7	5.6	6.7	26.6
All other miscellaneous and technical changes	(2)	(2)	(2)	(2)	(2)	(2)	(2)	−.1
Total for all changes	22.8	19.2	13.9	15.3	18.0	35.8	41.2	166.2

[1] New additional taxes of less than $50 million.

[2] Additional benefits of less than $50 million.

[3] Reduction in benefits of less than $50 million.

Note. Estimates shown for each provision include the effects of interaction with all preceding provisions. Totals do not always equal the sum of components due to rounding. Positive figures represent additional income or reduction in benefits. Negative figures reductions in income or increases in benefits.

Source: Office of the Actuary, Social Security Administration, 1983.

LEGISLATIVE CHANGES IN THE 99TH CONGRESS

Several legislative changes were made in the Social Security program in the 99th Congress. The Consolidated Omnibus Reconciliation Act of 1985 (Public Law 99-272) included a variety of minor and technical legislative changes in Social Security. Additionally, Public Law 99-272 contained provisions to: (a) exempt wages paid retired Federal judges performing active duty for the purposes of the FICA taxation and the Social Security earnings limitation; and (b) to protect certain Social Security beneficiaries who receive overpayments through the electronic direct deposit system.

The Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) included two significant Social Security provisions. The first eliminated the requirement that the annual rise in the Consumer Price Index must exceed 3 percent in order for a cost-of-living adjustment to be paid to Social Security beneficiaries. Under the new law, a cost-of-living adjustment will be paid in any year in which there is a measurable increase in consumer inflation. Secondly, Public Law 99-509 removed from the States the responsibility for collecting and depositing with the Federal Government Social Security contributions on behalf of their political subdivisions. All State and local entities now deposit their Social Security contributions directly to the Federal Government on a time schedule that parallels the treatment of private employers.

The Emergency Deficit Reduction and Balanced Budget Act of 1985 (Public Law 99-177) contained a provision to remove the receipts and disbursements of the Social Security trust funds from the unified budget effective in fiscal year 1986, and to restrict consideration of legislative changes in Social Security as part of the congressional budget process. The new law contained measures to bring the Federal budget into balance by fiscal year 1991. Under it, Social Security income and outgo are used in calculating the Federal deficit, but benefits are exempt from any automatic cuts required to reduce the deficit. Moreover, the Act contained provisions making it difficult for Social Security changes to be brought up in the congressional budget process by permitting the raising of "points of order" against such measures.

LEGISLATIVE CHANGES IN THE 1ST SESSION OF THE 100TH CONGRESS

Extend FICA tax to certain earnings

Armed Services reservists.—FICA taxes were extended to "inactive duty training" (generally weekend training drill sessions).

Agricultural workers.—FICA tax treatment of agricultural labor was modified such that: (a) any remuneration for agricultural labor paid by an employer to an employee would constitute wages if the employer pays more than $2,500 to all employees for such labor during the taxable year; (b) the $150 annual cash pay test would continue to be applied if the $2,500 annual payroll test is not met; and (c) the 20-day test would be eliminated.

Individuals aged 18-21.—FICA taxes were extended to services performed by individuals between the ages of 18 and 21 who are employed in their parent's trade or business.

Spouses.—FICA taxes were extended to services performed by an individual in the employ of his or her spouse's trade or business.

Tips.—The employer's share of FICA taxes was extended to include all cash tips (up to the Social Security wage base).

Treatment of group-term life insurance wages under FICA

Employer-provided group-term life insurance was included in wages for FICA tax purposes if such insurance were includable for gross income tax purposes, effective January 1, 1988.

Correction in government pension offset

Federal employees who switch from the Civil Service Retirement System (CSRS) to the Federal Employees' Retirement System (FERS) on or after January 1, 1988 were exempted from the government pension offset only if they had 5 or more years of Federal employment covered by Social Security after December 31, 1987.

Continuation of disability benefits pending appeal

The existing provision for continued payment of disability benefits during the administrative appeal process was extended for 1 additional year.

Lengthening the extended period of eligibility for disability benefits

The extended period of eligibility during which a disability beneficiary who returns to work may become automatically reentitled to benefits was lengthened from the current 15 months to 36 months. Medicare eligibility is not continued beyond the period provided under current law.

Payment of attorneys' fees

The administrative policy which permits ALJ's to authorize attorneys' fees of up to $3,000 without approval by an SSA regional office was reinstated.

CHARACTERISTICS OF BENEFICIARY POPULATION

Tables 14 through 16 provide detailed information on the numbers of various OASDI beneficiaries, the average amount of monthly benefits by type of beneficiary for new awards and for all beneficiaries currently receiving payments. More detailed information is shown in table 15 for December 1986.

TABLE 14.—OASI CASH BENEFITS: AVERAGE AMOUNT OF MONTHLY BENEFITS BY TYPE AND NUMBER OF BENEFICIARIES, CURRENT PAYMENT STATUS, DECEMBER 1987, AND NEW AWARDS, 1987

	Current payment		New awards	
	Number (in thousands)	Average payment	Number (in thousands)	Average payment
Retired workers	23,440	$513	1,682	$486
Wives and husbands of retired workers	3,090	264	333	239
Children of retired workers	440	216	118	215
Surviving children	1,836	352	311	350
Widowed mothers and fathers	329	353	65	343
Widows and widowers	4,879	468	475	468
Parents	8	407	.3	434

Source: Office of Research and Statistics, Social Security Administration.

TABLE 15.—NUMBER OF PERSONS RECEIVING VARIOUS TYPES OF OASDI BENEFITS BY AGE, SEX, AND AVERAGE MONTHLY BENEFIT AMOUNTS, DECEMBER 1986

[Based on 10-percent sample]

Benefits by age and sex	Number (thousands)	Percent of total beneficiaries	Average monthly benefit	Percentage of total benefits
Retired workers:				
Men:				
62 to 64	1,312	3.5	$486	3.9
65 to 69	3,662	9.7	541	12.0
70 to 79	5,189	13.8	587	18.4
80 to 89	1,683	4.5	515	5.2
90 and over	217	.6	466	.6
Total, retired men	12,063	32.1	550	40.2
Women:				
62 to 64	1,175	3.1	313	2.2
65 to 69	2,901	7.7	392	6.9
70 to 79	4,546	12.1	460	12.7
80 to 89	1,922	5.1	444	5.2
90 and over	332	.9	382	.8
Total, retired women	10,875	28.9	421	27.7
Total, retired workers	22,939	60.9	489	67.9
Disabled workers:				
Men:				
Under 50	639	1.7	504	1.9
50 to 59	609	1.6	547	2.0
60 to 61	209	.6	562	.7
62 to 64	363	1.0	569	1.3
Total, disabled men	1,820	4.8	538	5.9
Women:				
Under 50	291	.8	407	.7
50 to 59	313	.8	369	.7
60 to 61	107	.3	373	.2
62 to 64	187	.5	379	.4
Total, disabled women	899	2.4	384	2.1
Total, disabled workers	2,719	7.2	487	8.0

TABLE 15.—NUMBER OF PERSONS RECEIVING VARIOUS TYPES OF OASDI BENEFITS BY AGE, SEX, AND AVERAGE MONTHLY BENEFIT AMOUNTS, DECEMBER 1986—Continued

[Based on 10-percent sample]

Benefits by age and sex	Number (thousands)	Percent of total beneficiaries	Average monthly benefit	Percentage of total benefits
Spouses of retired workers:				
With entitled children:				
Under 35	5	(1)	127	(1)
35 to 44	21	.1	140	(1)
45 to 54	35	.1	157	(1)
55 to 64	41	.1	190	(1)
Total, with entitled children	102	.3	165	.1
Without entitled children: 62 and over	2,982	7.9	255	4.6
Total, spouses of retired workers	3,085	8.2	252	4.7
Spouses of disabled workers:				
With entitled children:				
Under 35	59	.2	97	(1)
35 to 44	96	.3	119	.1
45 to 54	56	.1	138	(1)
55 to 64	14	(1)	156	(1)
Total, with entitled children	225	.6	120	.2
Without entitled children: 62 and over	75	.2	163	.1
Total, spouses of disabled workers	299	.8	131	.2
Children:				
Children of retired workers:				
0 to 6	21	.1	150	(1)
7 to 10	36	.1	150	(1)
11 to 17	216	.6	192	.3
18 to 19 (students)	13	(1)	238	(1)
Disabled children 18 and over to	164	.4	237	.2
Total, children of retired workers	451	1.2	205	.6
Children of deceased workers:				
0 to 6	153	.4	292	.3
7 to 10	264	.7	316	.5
11 to 17	1,053	2.8	353	2.3
18 to 19 (students)	51	.1	374	.1
Disabled children 18 and over	351	.9	324	.7
Total, children of deceased workers	1,873	5.0	338	3.8
Children of disabled workers:				
0 to 6	144	.4	109	.1
7 to 10	181	.5	118	.1

TABLE 15.—NUMBER OF PERSONS RECEIVING VARIOUS TYPES OF OASDI BENEFITS BY AGE, SEX, AND AVERAGE MONTHLY BENEFIT AMOUNTS, DECEMBER 1986—Continued

[Based on 10-percent sample]

Benefits by age and sex	Number (thousands)	Percent of total beneficiaries	Average monthly benefit	Percentage of total benefits
11 to 17	581	1.5	152	.5
18 to 19 (student)	20	.1	199	(1)
Disabled children 18 and over	35	.1	187	(1)
Total, children of disabled workers	961	2.6	141	.8
Total, children	3,285	8.7	262	5.2
Widowed mothers and fathers:				
Under 30	38	.1	317	.1
30 to 39	131	.3	329	.3
40 to 49	112	.3	349	.2
50 to 59	56	.1	352	.1
60 to 61	6	(1)	361	(1)
62 and over	9	(1)	359	(1)
Total, widowed mothers and fathers	352	.9	339	.7
Widows (nondisabled):				
60 to 61	187	.5	414	.5
62 to 64	456	1.2	425	1.2
65 to 69	867	2.3	457	2.4
70 to 79	1,742	4.6	454	4.8
80 to 89	1,232	3.3	445	3.3
90 and over	302	.8	410	.7
Total, widows	4,786	12.7	445	12.9
Widowers (nondisabled):				
62 to 64	14	(1)	324	(1)
65 to 69	5	(1)	370	(1)
70 to 74	4	(1)	329	(1)
75 to 79	4	(1)	314	(1)
80 to 84	3	(1)	313	(1)
85 and over	3	(1)	305	(1)
Total, widowers	32	.1	328	.1
Disabled widows and widowers:				
50 to 54	12	(1)	316	(1)
55 to 59	37	.1	321	.1
60	12	(1)	312	(1)
61	11	(1)	321	(1)
62 and over	35	.1	321	.1
Total, disabled widows and widowers	107	.3	319	.2

TABLE 15.—NUMBER OF PERSONS RECEIVING VARIOUS TYPES OF OASDI BENEFITS BY AGE, SEX, AND AVERAGE MONTHLY BENEFIT AMOUNTS, DECEMBER 1986—Continued

[Based on 10-percent sample]

Benefits by age and sex	Number (thousands)	Percent of total beneficiaries	Average monthly benefit	Percentage of total benefits
Disabled widows	105	.3	321	.2
Disabled widowers	2	(1)	196	(1)
Parents: Total	9	(1)	387	(1)
Special age 72 beneficiaries (primary):				
Men	2	(1)	139	(1)
Women	22	.1	139	(1)
Total special age 72 beneficiaries	25	.1	139	(1)
Total	37,637	100.0	439	100.0

[1] Less than 0.1 percent.

Note.—Columns may not add due to rounding

Source: Office of Research and Statistics, Social Security Administration.

TABLE 16.—PERCENT OF SOCIAL SECURITY RETIRED-WORKER BENEFICIARIES RECEIVING REDUCED BENEFITS BECAUSE OF ENTITLEMENT BEFORE AGE 65, AS OF DECEMBER OF GIVEN YEAR

[Number column in millions]

Year	Total		Men		Women	
	Number	Percent	Number	Percent	Number	Percent
1956	5.1	2	3.6	(1)	1.5	7
1960	8.1	12	5.2	(1)	2.8	33
1965	11.1	32	6.8	21	4.3	49
1970	13.3	45	7.7	36	5.7	58
1975	16.6	56	9.2	49	7.4	66
1980	19.6	62	10.5	56	9.1	69
1985	22.4	66	11.8	61	10.6	71
1986	23.0	66	12.1	62	10.9	72
1987 [2]	23.2	67	12.2	62	11.0	72

[1] Reduced benefits were not available to men until 1961. They were not available to women until 1956.
[2] Data are for June 1987.

Source: Social Security Bulletin, Table Q–2.

The previous three tables have shown the number and average benefit classified by type of beneficiary and the percent who retire early. Many individuals receive benefits on their own record plus other benefits based upon earnings of their spouse or former spouse. Table 17 separates, by type of female beneficiary, the amount of benefits received on her own earnings record versus someone else's. For example, 9.9 million female beneficiaries over age 65 are insured and receive an average benefit of $454 or total benefits of $4.5 million. Some 6.8 million female beneficiaries over age 64 who are not insured receive an average benefit of $396. These benefits were all earned by a spouse or former spouse. Most of these benefits represent a survivor benefit. Table 18 presents similar information for male beneficiaries.

TABLE 17.—OASDI MONTHLY BENEFITS RECEIVED BY FEMALES IN DECEMBER 1987 [1]

[Numbers in thousands; amounts in millions except averages]

Age	Total OASDI benefit	Based on own earnings record		Benefit received as dependent spouse			Benefit received mother, parent, special primary	Percent of total female benefits
		Old-Age	Disability	Retirement	Survivor	Disability		
65 and over (insured):								
Number	9,948	9.948		[2] 1,405	[2] 2.325		[2] 2	
Total benefits	$4,520	$3,807		$154	$559		[3]	
Average	$454.36	$382.67		$109.52	$240.37		220.90	52.8
65 and over (not insured):								
Number	6,772			2,498	4,217	31	25	
Total benefits	$2,685			$681	$1,993	$5	$6	
Average	$396.48			$272.64	$472.53	$171.84	$225.93	31.4
62 to 64 (insured):								
Number	1,384	1,196	187	[2] 349	[2] 33		([2] [4])	
Total benefits	$470	$349	$74	$37	$10		([3])	
Average	$339.98	$291.51	$395.07	$106.86	$315.36		$318.80	5.5
62 to 64 (not insured):								
Number	1,004			473	480	43	8	
Total benefits	$338			$116	$211	$8	$3	
Average	$336.47			$244.74	$440.26	$176.27	$386.38	3.9
Less than 62:								
Number	1,595		741	86	252	210	305	
Total benefits	$550		$297	$14	$103	$26	$109	
Average	$344.77		$400.83	$168.20	$408.59	$122.13	$358.57	6.4
Total number	20,703	11,145	929	3,056	4,950	285	339	
Total benefits	$8,563	$4,156	$371	$1,002	$2,877	$39	$119	100.0
Average	$413.62	$372.89	$399.67	$327.95	$581.13	$135.83	$350.69	
Percent of total female benefits	100.0	48.5	4.3	11.7	33.6	0.5	1.4	

[1] Table does include female child beneficiaries. [2] Dually entitled. [3] Less than $500,000. [4] Less than 500.

Source: Office of the Actuary, Social Security Administration.

TABLE 18.—OASDI MONTHLY BENEFITS RECEIVED BY MALES IN DECEMBER 1987 [1]

[Numbers in thousands; amounts in millions except averages]

Age	Total OASDI benefit	Based on own earnings record		Benefit received as dependent spouse			Benefit received father, parent, special primary	Percent of total male benefits
		Old-Age	Disability	Retirement	Survivor	Disability		
65 and over (insured):								
Number	10,961	10,961		(2)	(2)		(2)	
Total benefits	$6,406	$6,406						78.4
Average	$584.42	$584.42						
65 and over (not insured):								
Number	54			33	19	1	2	
Total benefits	$13			$6	$6	(3)	(3)	0.2
Average	$234.40			$177.52	$346.12	$112.23	$198.28	
62 to 64 (insured):								
Number	1,695	1,334	361	(2)	(2)		(2)	
Total benefits	$909	$694	$216					11.1
Average	$536.57	$520.75	$596.75					
62 to 64 (not insured):								
Number	10			1	9	(4)	(4)	
Total benefits	$3			(3)	$3	(3)	(3)	(5)
Average	$330.14			$130.62	$362.62	$99.10	$282.20	
Less than 62:								
Number	1,522		1,496	(4)	6	5	15	
Total benefits	$834		$829	(3)	$2	(3)	$3	10.2
Average	$548.19		$554.22	$90.91	$269.78	$78.95	$214.74	
Total number	14,243	12,295	1,857	34	34	6	17	
Total benefits	$8,166	$7,100	$1,045	$6	$11	$1	$4	100.0
Average	$573.33	$577.46	$562.49	$175.86	$335.87	$86.11	$213.21	
Percent of total male benefits	100.0	86.9	12.8	0.1	0.1	(5)	(5)	

[1] Table does include male child beneficiaries. [2] Assumes all dually-entitled beneficiaries are female. [3] Less than $500,000. [4] Less than 500.

[5] Less than 0.05 percent.

Source: Office of the Actuary, Social Security Administration.

TABLE 19.—1988 SUMMARY SOCIAL SECURITY INFORMATION

Tax rate:	
Employee and employer each	7.51 percent (6.06 percent—OASDI, 1.45 percent—HI).
Self-employed	15.02 percent (12.12 percent—OASDI, 2.90 percent—HI).
Wage Base	$45,000.
Quarter of Coverage	$470 equals 1 QC.
Retirement Test Exempt Earnings Limits:	
Age 65 and over	$8,400 annual, $700.00 monthly.
Under age 65	$6,120 annual, $510.00 monthly.

Bend Points:

PIA	Maximum Family Benefit
90 percent of first $319 of AIME, plus 32 percent of AIME over $319 thru $1,922, plus 15 percent of AIME over $1,922.	150 percent of first $407 of PIA, plus 272 percent of PIA over $407 thru $588, plus 134 percent of PIA over $588 thru $767, plus 175 percent of PIA over $767.

Benefit Examples:

Retired Worker Age 65 in 1988—January 1988 PIA	Long-Range Constant Replacement Rate Under Decoupled System [1]
Fed. minimum wage earner, $412.00	Fed. minimum wage earner, 60 percent.
Average earner, $626.20	Average earner, 41 percent.
Maximum earner, $838.60	Maximum earner, 27 percent.

Average Earnings Level: 1986—$17,322; 1987 est.—$18,036.[2]
Federal Minimum Wage Level:[3] 1986—$6,968; 1987—$6,968.

Poverty level	1983 (actual)	1984 (actual)	1985 (actual)	1986 (actual)	1987 (est.)
Aged individual	$4,775	$4,979	$5,156	$5,255	$5,476
Couple, aged head	6,023	6,282	6,503	6,630	6,908
Family of four	10,178	10,609	10,989	11,203	11,674

[1] For retirement at normal retirement age in 2030 and later.
[2] 1987 Trustees' Report—alternative II-B assumptions.
[3] 2,080 hours times the hourly Federal minimum wage.

Source: Office of Legislative and Regulatory Policy, Social Security Administration.

TABLE 20.—MONTHLY BENEFIT AMOUNTS FOR SELECTED BENEFICIARY FAMILIES WITH FIRST ELIGIBILITY IN 1987, BY AVERAGE INDEXED MONTHLY EARNINGS FOR SELECTED WAGE LEVELS, EFFECTIVE DECEMBER 1987

Beneficiary family	Worker with yearly earnings equal to—				
	The Federal minimum wage [1]	75 percent of the average wage	Average wage [2]	150 percent of the average wage	The maximum wage creditable [3]
Retired worker families [4]					
Average indexed monthly earnings	$740.00	$1,052.00	$1,403.00	$1,900.00	$2,205.00
Primary insurance amount	434.00	538.00	655.10	814.80	862.40
Maximum family benefit	677.30	960.00	1,195.40	1,425.30	1,508.60
Monthly benefit amount—Retired worker claiming benefits at age 62: [4]					
Worker alone	347.00	430.00	524.00	651.00	689.00
Worker with spouse claiming benefits at—					
Age 65 or older	564.00	699.00	851.00	1,058.00	1,120.00
Age 62	509.00	631.00	769.00	956.00	1,012.00
Survivor families [5]					
Average indexed monthly earnings	714.00	1,053.00	1,405.00	2,107.00	2,834.00
Primary insurance amount	425.30	538.40	655.80	847.10	960.80
Maximum family benefit	653.40	961.00	1,196.40	1,481.80	1,680.70
Monthly benefit amount—Survivors of worker deceased at age 40: [5]					
1 surviving child	318.00	403.00	491.00	635.00	720.00
Widowed mother or father and 1 child	636.00	806.00	982.00	1,270.00	1,440.00
Widowed mother or father and 2 children	651.00	960.00	1,194.00	1,479.00	1,680.00
Disabled worker families [6]					
Average indexed monthly earnings	739.00	1,052.00	1,403.00	1,978.00	2,389.00
Primary insurance amount	433.60	538.00	655.10	827.00	891.20
Disability maximum family benefit [7]	650.50	807.10	982.60	1,240.50	1,336.70
Monthly benefit amount—Disabled worker age 50: [6]					
Worker alone	433.00	538.00	655.00	827.00	891.00
Worker, spouse, and 1 child	649.00	806.00	981.00	1,239.00	1,335.00

[1] Worker earned the Federal minimum wage (currently $3.35 per hour) and worked 2,080 hours per year in all years used in the computation of the benefit.

[2] Worker earned the national average wage in each year used in the computation of the benefit.

[3] Worker earned the maximum amount of wages that can be credited to a worker's Social Security record in all years used in the computation of the benefit.

[4] Assumes the worker retired at age 62 in 1987 and had no prior period of disability.

[5] Assumes the deceased worker began to work at age 22, was deceased in 1987 at age 40, had no earnings in that year, and had no prior period of disability.

[6] Assumes the worker began to work at age 22, became disabled in 1987 at age 50, and had no prior period of disability.

[7] The 1980 Amendments to the Social Security Act provide for different family maximum amount for disability cases. For disabled workers entitled after June 1980, the maximum is the smaller of (1) 85 percent of the worker's AIME (or 100 percent of the PIA, if larger) or (2) 150 percent of the PIA.

Source: Office of Research and Statistics, Social Security Administration.

TABLE 21.—EFFECT OF TAXING SOCIAL SECURITY BENEFITS, BY INCOME CLASS, 1989

Level of individual or couple income [1]	Persons 65 and over		All recipients		Aggregate amount of Social Security benefits (in billions of dollars)	Aggregate amount of taxes on benefits (in billions of dollars)	Taxes as a percent of benefits
	Number (in thousands)	Number affected by taxation of benefits [2] (in thousands)	Number of Social Security beneficiaries [3] (in thousands)	Number affected by taxation of benefits (in thousands)			
Less than $10,000	9,124	0	11,560	0	53.7	0	0.0
$10,000 to $15,000	4,290	0	5,184	0	30.8	0	0.0
$15,000 to $20,000	3,483	0	4,094	0	25.7	0	0.0
$20,000 to $25,000	2,884	0	3,518	0	22.2	0	0.0
$25,000 to $30,000	2,278	122	2,751	167	17.5	(4)	0.1
$30,000 to $40,000	3,161	927	3,612	1,180	23.3	0.4	1.7
$40,000 to $50,000	1,657	1,430	1,810	1,710	12.3	.7	5.5
$50,000 to $100,000	2,119	1,891	2,224	2,217	15.0	1.9	12.8
At least $100,000	663	549	567	567	3.9	.6	15.5
All	29,659	4,919	35,319	5,840	204.4	3.6	1.8

[1] Cash income (based on income of tax filing unit), plus capital gains realizations.

[2] Some elderly individuals do not receive Social Security benefits and are thus not affected by taxation of benefits.

[3] Includes beneficiaries under and over age 65.

[4] Less than $50 million.

Note.—Aggregate benefits and revenues are understated by about 10 percent because of benefits paid abroad, deaths of recipients before March interview, and exclusion of institutionalized beneficiaries. The number of beneficiaries is also understated.

Source: Congressional Budget Office, based on data from the Current Population Survey (CPS).

Section 2. Disability Insurance Program

The disability insurance (DI) program provides monthly cash benefits for disabled workers under age 65 and their dependents. Benefits for the disabled were provided to disabled workers age 50 or older by the 1956 Social Security Amendments; benefits for their dependents were provided by the 1958 Social Security Amendments. Benefits to disabled workers under age 50 were provided by the 1960 amendments.

GENERAL

Many provisions of the DI program are identical to those of the OASI program. For example, all workers who are covered by OASI are also covered by DI. Contributions are made under the same provision of the Internal Revenue Code and are made on the same wage base.

The DI portion of the OASDI tax is allocated to the Disability Insurance Trust Fund which is the source of payment for monthly benefits to disabled workers and their dependents and for administrative expenses of the program. In addition, the revenue derived from the taxation of disability benefits is also credited to the trust fund.

The purpose of both OASI and DI benefits is to replace income lost when the wage-earner is no longer able to work. However, significant differences exist between the two programs, primarily because of the different nature of the event insured. The OASI program insures a worker, his dependents and survivors against loss of income due to the worker's retirement or death. The DI program insures against the loss of income due to the worker's physical or mental disability. In addition, the OASI program is administered solely by Federal employees in Federal installations, whereas the DI program is administered both through Federal Social Security offices and State disability determination services staffed by State employees.

BENEFITS

Summary

Monthly cash benefits are paid and computed generally on the same basis as in the OASI program. Benefit amounts are related to the past earnings of the insured worker.

In December 1987 there were 4.0 million DI beneficiaries in current-payment status. The total monthly benefits paid out were $1.60 billion. Table 1 summarizes various types of beneficiaries of the DI program currently receiving benefits, and average benefit amounts and the number of new awards during 1987.

TABLE 1.—DISABILITY CASH BENEFITS: NUMBER IN CURRENT PAYMENT STATUS AND AVERAGE BENEFIT AMOUNT (DECEMBER 1987) AND NUMBER OF BENEFITS AWARDED DURING THE YEAR AND AVERAGE BENEFIT AMOUNT, 1987

	Current payment		New awards	
	Number (in thousands)	Average payment	Number (in thousands)	Average payment
Disabled workers	2,786	$508	416	$508
Wives and husbands of workers	291	135	77	133
Children of disabled workers	968	146	257	136

Source: Office of Research and Statistics, Social Security Administration.

Description of major benefit types

Disabled-worker benefit.—A monthly benefit payable to a disabled worker under age 65 insured for disability.

Spouses' benefit.—Monthly benefit payable to a spouse or divorced spouse of a disabled worker under one of the following conditions: (1) wife or husband is aged 62 or older or has 1 or more entitled children of the worker under age 16 in his or her care; or (2) divorced wife (husband) is aged 62 or older and her (his) marriage to worker lasted 10 years (20 years for benefits paid or applications filed before January 1979) before divorce became final.

Child's benefit.—A monthly benefit payable to an unmarried child or eligible grandchild of a disabled worker.

Disabled child's benefit.—A monthly benefit payable to a disabled person aged 18 or over—a dependent son or daughter or eligible grandson or granddaughter of a retired, deceased, or disabled worker—whose disability began before age 22.

Definition of disability

Generally, disability is defined as an inability to engage in any substantial gainful activity by reason of a physical or mental impairment. The impairment must be medically determinable and expected to last for not less than 12 months or to result in death. A person (other than a disabled widow or widower) may be determined to be disabled only if due to this impairment he is unable to engage in any kind of substantial gainful work, considering his age, education, and work experience, which exists in the national economy even though such work does not exist in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work.

There are special definition and eligibility requirements for persons who are blind.

A widow (or widower) can be determined to be disabled only if a physical or mental impairment exists of such a level of severity that makes it impossible to perform any gainful work (rather than substantial gainful work).

Waiting period

An initial 5-month waiting period is required before DI benefits will be paid. Benefits are payable for the 6th month. However, benefits may be paid for the 1st full month of disability to a worker who becomes disabled within 60 months (for a disabled widow or widower the period is 84 months) after termination of DI benefits from an earlier period of disability.

Insured status

Workers are *insured for disability* if they are fully insured and, except for persons who are blind or disabled before age 31, have a total of at least 20 quarters of coverage during the 40-quarter period ending with the quarter in which the worker became disabled. Workers who are disabled before age 31 must have total quarters of coverage equal to half the calendar quarters which have elapsed since the worker reached age 21, ending in the quarter in which the worker became disabled. However, a minimum of 6 quarters is required.

BENEFIT COMPUTATION

DI benefits are computed in the same manner as old age and survivors benefits except that the number of years of earnings which is excluded when determining the benefit amount is less than 5 for workers under age 47. The number of drop-out years allowed increases with the age of the insured worker`at disablement. The amount of the monthly benefit is based on the insured worker's primary insurance amount (PIA).

The following table lists major disability benefits with the percentage of the insured worker's PIA.

TYPE OF MONTHLY BENEFIT

	Percent of PIA
Disabled worker (any age)	100
Dependents of disabled worker: [1] Wife or husband (age 62), mother, father, children and grandchildren	50
Survivors: [1] Disabled (age 50–59), widows or widowers	71.5

[1] Subject to maximum family benefit limitation.

Substantial gainful activity

The Secretary of HHS[1] has specific regulatory authority to prescribe the criteria for determining when earnings derived from employment demonstrate an individual's ability to engage in substantial gainful activity (SGA).

The Secretary has published regulations specifying the monetary amounts which indicate substantial gainful activity. At the present time the SGA earnings level is $300 a month (net of impairment-related work expenses).

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[1] Throughout the remainder of this section when Secretary is used, it is the Secretary of Health and Human Services.

Trial work period

Under a provision enacted in December 1987, a 45-month period of extended eligibility for Social Security benefits is provided to disabled beneficiaries who attempt to work. The period consists of (1) a 9-month "trial work period" during which benefits are not suspended because of work, and (2) a 36-month "extended period of eligibility," during the last 33 of which benefits are suspended for any month in which the individual is engaged in substantial gainful activity (SGA). However, during the extended period of eligibility, entitlement to benefits is not terminated. Medicare benefits may be continued for 48 months after the trial work period begins.[2]

If an individual medically recovers to the extent that he no longer meets the definition of disability, benefits are terminated regardless of the "trial work" provision. Only one trial work period is permitted for each period of disability. Beneficiaries who qualified for benefits without a waiting period are not entitled to a trial work period. The Secretary of HHS has provided by regulation that earnings of $75 a month will constitute a month of "trial work."

DI maximum family benefit

The maximum monthly amount of DI family benefits which is payable on a disabled worker's earnings record for workers who first become entitled after June 1980, is the smaller of 85 percent of the worker's average indexed monthly earnings or 150 percent of the worker's primary insurance amount. However, in no case can the benefit be reduced below 100 percent of the worker's primary insurance amount.

Offset for other public disability benefits

When a disabled worker under age 65 qualifies on the basis of total or partial disability (whether or not permanent) for benefits which are provided by Federal, State and local governments and worker's compensation, the Social Security benefits payable to him and his family are reduced by the amount, if any, that the total monthly benefits payable under the two or more programs exceed 80 percent of his average current earnings before he became disabled. Needs-tested benefits, Veterans' Administration disability benefits, and benefits based on public employment covered by Social Security are not subject to the provision. A worker's average current earnings for this purpose are the larger of (a) the average monthly earnings used for computing his Social Security benefits, or (b) his average monthly earnings in employment or self-employment covered by Social Security during the 5 consecutive years of highest covered earnings after 1950, or (c) the average monthly earnings during the calendar year of highest earnings during a period consisting of the year in which disability began and the preceding 5 years without regard to the limitations which specify a maximum amount of earnings creditable for Social Security benefits. The combined payments after the reduction are never less than the total amount of the DI benefits payable before the reduction. In addition, the Social Security benefit is increased by the full amount of the cost-of-living increase as applied to the unreduced benefit. Every 3 years the original amount of benefits subject to reduction is redetermined to reflect changes in average wage levels. If increases in the average national wages would result in a higher benefit than that payable based on the original computation, the benefit is increased effective January of the redetermination year.

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[2] The continuation of Medicare benefits of a disabled worker was not affected by the recent lengthening of the trial work period for DI benefits. Under the law, Medicare benefits are paid for 24 months following the month that DI benefits would have been terminated after the "old law" trial work period (which was a maximum of 24 months).

The offset begins in the month during which concurrent entitlement begins under a Federal or State law.

The offset of the Social Security disability benefit will not be made if the State worker's compensation law provides for an offset against Social Security disability benefits. However, this waiver of the offset only applies where the State program began offsetting on or before February 18, 1981.

DETERMINATION OF DISABILITY

State agency determinations of disability

Disability determinations are made by State agencies which agree to make such determinations and substantially comply with the regulations of the Secretary. The Secretary is required to issue regulations specifying, in such detail as he or she deems appropriate, performance standards and administrative requirements and procedures to be followed in performing the disability determination function "in order to assure effective and uniform administration of the disability insurance program throughout the United States." Certain operational areas are cited as "examples" of what the regulations may specify. These include such items as the nature of the administrative structure, the physical location of and relationship among agency staff units, performance criteria and fiscal control procedures.

The law also provides that if the Secretary finds that a State agency is substantially failing to make disability determinations consistent with his regulations, the Secretary shall, not earlier than 180 days following his findings, terminate State administration and make the determinations himself. The law also allows for termination by the State. The State would be required to continue to make disability determinations for not less than 180 days after notifying the Secretary of its intent to terminate. Thereafter, the Secretary would be required to make the determinations.

Determining disability: Application of law and regulations

The adjudication of claims is accomplished on a sequential basis. Whether the individual is currently employed and the amount of earnings are the first factors considered. If the individual is earning the amount that indicates ability to engage in "substantial gainful activity" (SGA, now $300 a month), he is determined not disabled. If he is making less than this amount or not working at all, the severity and duration of the impairment are explored. If the severity is determined to be "not severe", the individual is denied right at that point. If it neither "meets" nor "equals" the specified standard (which will result in an allowance) but meets the 12-month duration rule, a determination is then made of whether the claimant is able to carry out his former occupation. If he can, he is denied benefits; if he cannot, the nonmedical factors come into play. It is important to note that the "severity" step had become very controversial in recent years, with several Federal circuit courts ruling that SSA's procedures violate the intent of the law that every claimant receive an individual determination based on medical and vocational factors. However, in a recent decision, the Supreme Court, while raising a number of concerns about SSA's procedures, upheld the Agency's application of the "severity" test at this stage of the sequential process.[3] If the impairment is "severe," a determination is made as to whether the impairment "meets" or "equals" the level of severity spelled out in the regulations[4] and whether it will last for 12 months.

At this stage, because of a judicial opinion and subsequent administrative and legislative ratification, the burden of proof switches to the Government to show that the individual can, considering his impairment, age, education, and work experience, engage in some other kind of substantial gainful activity which exists in a national economy. Such work, however, does not have to exist in the immediate area in which he lives and a specific job vacancy does not have to be available to him. Work in the national economy is defined in the law as a job which exists in significant numbers either in the region where such individual lives or in several regions of the country.

In the face of a growing number of nonmedical allowances and a declining number of cases where the medical listings were met, SSA in 1976 developed a vocational "grid" designed to reduce the subjectivity and lack of uniformity in applying the vocational factor. The grid regulations were designed to embody in a formula certain worker characteristics such as age, education, and past work experience, in relation to the individual's residual functional capacity (RFC) to perform work-related physical and mental activities. If the claimant has a particular level of residual work capability—characterized by the terms Sedentary, Light, Medium, Heavy and Very Heavy—an automatic finding of "disabled" or "not disabled" is required when applied to various combinations of age, education, and work experience.

The regulations were finally promulgated in February 1979 after some lengthy administrative hearings and consideration. During the period 1975–1983, there was a decline at the State agency level in the number of nonmedical allowances and an increase in the percentage of allowed cases which "met" or "equaled" the medical listings. Those percentages are presented in table 2 and show this trend has reversed itself since 1984. Moreover, there was an equally dramatic increase during the period from 1975 through 1983 in the number of denials on the basis of "impairment not severe" which under the sequential method of determining disability would exclude the consideration of the nonmedical factors. This trend also seems to have slowed since 1984. Table 3 gives a percentage distribution of the basis for denials at the initial determination of disability at the State agency level for fiscal years 1975 to 1987.

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[3] *Bowen* v. *Yuckert*, No. 85-1409, June 8, 1987.

[4] The Listing of Impairments contains over 100 examples of medical conditions that would ordinarily prevent an individual from engaging in any gainful activity. Each listing describes a degree of severity such that an individual who is not working and has such an impairment is considered unable to work by reason of the medical impairment. The listing describes specific medically acceptable clinical and laboratory findings and signs which establish the severity of the impairments. An impairment or combination of impairments is said to "equal the listings" if the medical findings for the impairment are at least equivalent in severity and duration to the listed findings of a listed impairment.

A widow or widower may qualify for benefits on the deceased spouse's work record at age 50 and over if he or she has "physical or mental impairments" at "a level of severity which under regulations prescribed by the Secretary is deemed to be sufficient to preclude an individual from engaging in any gainful activity." The regulations of the Secretary state that to qualify for disabled widows' benefits a person must have impairments which "meet the listings" or "are medically equivalent to those for any impairment shown there." Thus, vocational factors are not taken into account in determining the disability of a widow or widower.

TABLE 2.—BASIS FOR TITLE II ALLOWANCES—NATIONAL FIGURES: INITIAL WORKER DETERMINATION, FISCAL YEARS 1975–87

[In percent]

Fiscal year	Meets listing	Equals listing	Medical and vocational considerations
1975	29.4	43.9	26.7
1976	29.0	45.1	25.9
1977	34.2	41.9	23.9
1978	45.6	31.9	22.5
1979	55.1	22.7	22.1
1980	57.9	16.2	25.9
1981	63.9	12.3	23.8
1982	72.7	8.6	18.7
1983	74.0	8.3	17.7
1984	66.7	8.7	24.6
1985	62.7	9.2	28.1
1986	68.2	8.7	23.1
1987 [1]	64.3	8.0	27.7

[1] Based on preliminary quarterly data.

Source: Office of Disability, Social Security Administration.

TABLE 3.—BASIS FOR TITLE II DISALLOWANCES AND DENIALS—NATIONAL FIGURES: INITIAL WORK DETERMINATION, FISCAL YEARS 1975–87

[In percent]

	Duration	Slight impairment	Able to perform usual work	Able to perform other work	Engaging in SGA	Failure to cooperate	Failure to appear	Other
1975	19.6	8.4	44.3	18.2	1.0	5.1	1.8	1.6
1976	19.9	10.8	41.9	20.1	.4	4.8	1.8	.3
1977	21.2	24.8	30.0	15.7	.5	4.9	1.8	1.1
1978	21.1	31.8	25.0	14.6	.5	4.1	1.9	1.0
1979	20.0	41.6	21.5	12.5	.4	.9	2.3	.8
1980	20.6	39.0	23.7	12.7		1.9	1.3	.7
1981	17.5	43.2	18.7	11.3	2.0		2.6	4.8
1982	16.4	38.9	22.6	14.1	1.1		2.8	3.6
1983	16.9	39.4	22.0	14.3	1.0		3.0	3.4
1984	14.8	34.3	23.8	16.7	1.0	2.0	2.3	5.1
1985	15.4	23.3	35.4	20.3	1.1		2.2	2.3
1986	14.2	20.1	38.4	20.5	.2		2.5	4.1
1987 [1]	13.5	16.0	38.2	25.8	.1		2.1	4.3

[1] Based on preliminary quarterly data.

Source: Office of Disability, Social Security Administration.

Federal review of State determination

The Secretary may, on his own motion, review any determination by a State agency.

The law requires that 65 percent of allowances (or continuances) of disability shall be reviewed by the Secretary.

Periodic review of individuals receiving disability benefits

The 1980 Disability Amendments required that the Social Security Administration reexamine every individual on the rolls who is determined to be nonpermanently disabled for benefit eligibility at least once every 3 years. Where there is a finding of permanency, the Secretary may reexamine at such times as is determined to be appropriate. These reviews are in addition to the administrative eligibility review procedures existing prior to the 1980 amendments. Legislation enacted in late 1982 provided authority for the Secretary to slow down the rate of continuing eligibility reviews mandated by the 1980 amendments.

Medical improvement standard

The 1984 Disability Benefits Reform Act amended the law to require that in continuing eligibility review cases, benefits may be terminated only if the Secretary finds that there has been medical improvement in the person's condition and that this improvement has enabled the person to engage in substantial gainful activity. There are several statutory exceptions to this standard, which are described in greater detail in the "Recent Legislation" section of this chapter.

Medical evidence

An individual is not considered under a disability unless he furnishes such medical and other evidence as the Secretary may require.

Under the law, the Secretary will generally reimburse physicians or hospitals for supplying medical evidence in support of claims for DI benefits. The Secretary also pays for medical examinations if this is needed to adjudicate the claim.

Attorneys' fees and representation

At the administrative level the Secretary of HHS is authorized to fix a reasonable fee for the services provided for a Social Security applicant by an attorney and to pay such attorney's fee out of the applicant's past-due benefits. The amount that can be paid out of past-due benefits is limited to the smaller of (a) 25 percent of the past-due benefits; (b) the fee fixed by the Secretary; or (c) an amount agreed to by the applicant and the attorney. The Secretary certifies the payment to the attorney.

Under prior administrative policy, ALJ's are permitted to authorize attorneys' fees of up to $3,000 without approval by an SSA regional office. Early in 1987, SSA reduced this amount to $1,500. In response to the subsequent controversy and large backlog of cases which resulted, Congress reinstated the $3,000 limit in the Budget Reconciliation Act of 1987 (Public Law 100-203). (See "Recent Legislation.")

A court which renders a decision favorable to a claimant for social security benefits is permitted to set a reasonable fee for the attorney who represented the claimant before the court. The fee cannot exceed 25 percent of the past-due benefits which result from the court's decision. The Secretary may certify for payments to the attorney, out of the total of the past-due benefits, the amount of the fee set by the court.

VOCATIONAL REHABILITATION

The Social Security Act requires that disabled persons applying for a determination of disability be promptly referred to State vocational rehabilitation agencies for necessary rehabilitation services. The act provides for withholding of benefits for refusal, without good cause, to accept rehabilitation services available under a State plan approved under the Vocational Rehabilitation Act in such amounts as the Secretary shall determine.

Public Law 97-35 eliminated reimbursement from the trust funds to the State vocational rehabilitation agencies for rehabilitation services except in cases where the services have resulted in the beneficiary's performance of substantial gainful activity (SGA) for a continuous period of at least 9 months. Such a 9-month period could begin while the individual is under a vocational rehabilitation program and may also coincide with the trial work period or the individual's waiting period for benefits. The services must be performed under a State plan for vocational rehabilitation services under title I of the Rehabilitation Act. In the case of any State which is unwilling to participate or which does not have a plan which meets the requirements of the Vocational Rehabilitation Act, the Commissioner of Social Security may provide such services by agreement or contract with other public or private agencies, organizations, institutions or individuals. The determination that the VR services contributed to the successful return of the individual to SGA, and the determination of the amount of costs to be reimbursed, are made by the Commissioner of Social Security in accordance with criteria formulated by him. Payments under this provision can be made in advance or by way of reimbursement, with necessary adjustments for overpayments or underpayments.

DISABILITY CLAIMS AND APPEALS STRUCTURE

The Social Security appeals and case review process is a complex multilayered structure which is inextricably linked with the disability determination process. Since about 97 percent of the hearing requests involve disability claims (both Social Security and SSI), the process described will be for that type of claim. The application for disability benefits is made at the Federal Social Security district office where the claimant is interviewed and the sources of medical evidence are recorded. After determining whether the applicant meets the insured status requirements, the case is then sent to the State agency which, operating as an agent of the Social Security Administration, makes the initial determination of disability. If a claimant or terminated beneficiary is dissatisfied with an initial denial or termination of disability benefits by the State agency, he can request a reconsideration within 60 days of notice of denial. The reconsideration is also carried out by the State agency, but by personnel other than those who made the initial determination. If upon reconsideration the claimant is again denied benefits, he will be given a hearing before an administrative law judge (ALJ), providing he files a request within 60 days of notice of denial. If the claim is denied by the ALJ, the claimant has 60 days to request review by the Appeals Council. The Appeals Council may also, on its own motion, review a decision within 90 days of the ALJ's decision. The 1980 Disability Amendments required the Secretary to review a percentage of ALJ hearing decisions, and this review is being conducted by the Appeals Council.

The Appeals Council may review, affirm, modify or reverse the decision of the ALJ, or it may remand it to the ALJ for further development. The claimant is notified in writing of the final action of the Appeals Council, and is informed of his right to obtain further review by commencing a civil action within 60 days in a United States district court.

Under current law, as amended by the 1984 Disability Benefits Reform Act, DI beneficiaries whose benefits have been terminated for medical reasons, e.g., recovery or improvement in the medical condition which was the basis for the disability, can elect to continue to receive benefits through the appeals process. If the termination decision is upheld, however, the beneficiary must repay these benefits.

Table 4 shows the number of cases allowed and appealed at various levels of appeal for application decisions and Continuing Disability Reviews (CDRs) processed by State agencies. Of the 1,570,022 initial application decisions by State agencies in fiscal year 1987, some 36 percent were allowed and of the 174,800 CDRs 87 percent were continued in benefit status.

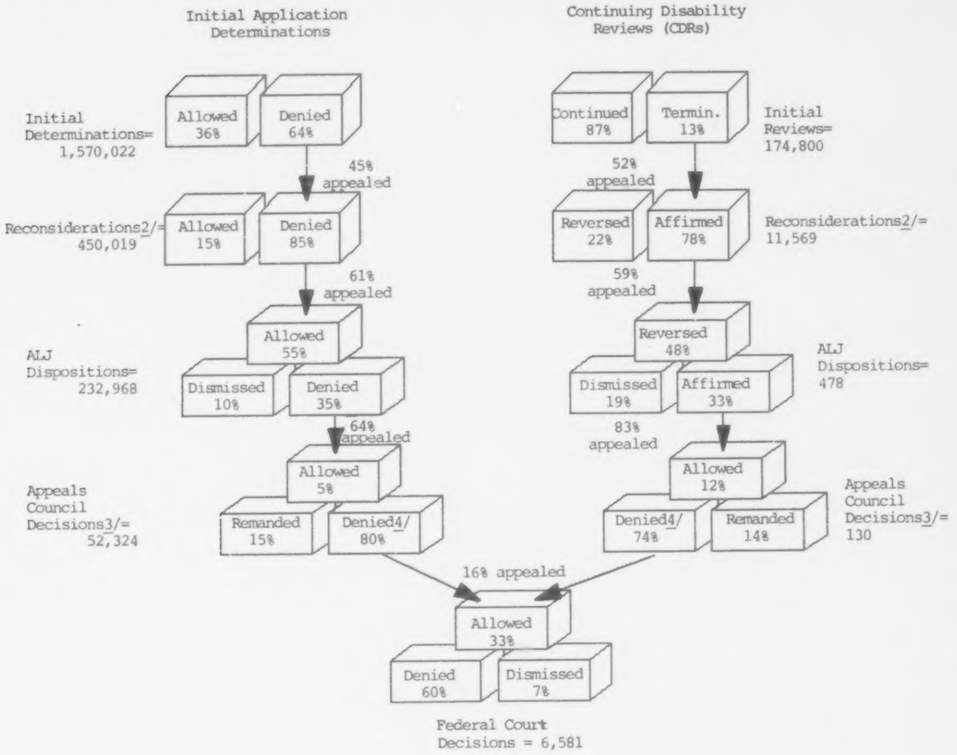
Of the initial application decisions some 64 percent were denied. Nearly half (45 percent) of these appealed their denials to the reconsideration level. After all levels of appeal had been exhausted, nearly 20 percent of those denied benefits initially had benefits granted to them through the appeals process. When appeals allowances are considered, some 51 percent of the initial application decisions were finally denied.

Of the initial CDRs some 13 percent were terminated. About half (52 percent) of these appealed their terminations. After all levels of appeal had been exhausted, nearly 13 percent of those terminated initially had continuation of benefits granted through the appeals process. When appeals continuances are considered, about 11 percent of the initial CDRs were finally terminated.

Table 5 presents information for fiscal years 1979 through 1987 of the number of cases which are reviewed and reversed at the administrative law judge level. Approximately 51.9 percent of initial denials were reversed in 1986 and 57.1 percent were reversed in 1987.

TABLE 4.—DISABILITY DETERMINATIONS AND APPEALS, FISCAL YEAR 1987

TITLE II, TITLE XVI AND CONCURRENT TITLE II AND XVI DECISIONS FOR DISABILITY CLAIMS BY WORKERS, WIDOWS, WIDOWERS AND DISABLED ADULT CHILDREN[1]


Initial Application Determinations
Continuing Disability Reviews (CDRs)
Initial Determinations= 1,570,022
Allowed 36%
Denied 64%
Continued 87%
Termin. 13%
Initial Reviews= 174,800
45% appealed
52% appealed
Reconsiderations2/= 450,019
Allowed 15%
Denied 85%
Reversed 22%
Affirmed 78%
Reconsiderations2/= 11,569
61% appealed
59% appealed
Allowed 55%
Reversed 48%
ALJ Dispositions= 232,968
Dismissed 10%
Denied 35%
Dismissed 19%
Affirmed 33%
ALJ Dispositions= 478
64% appealed
83% appealed
Allowed 5%
Allowed 12%
Appeals Council Decisions3/= 52,324
Remanded 15%
Denied4/ 80%
Denied4/ 74%
Remanded 14%
Appeals Council Decisions3/= 130
16% appealed
Allowed 33%
Denied 60%
Dismissed 7%
Federal Court Decisions = 6,581

% of Total Allowances	
Total	100.0
Initial Decisions 5/	78.3
Initial Application	(61.8)
CDR	(16.5)
Reconsiderations	7.4
ALJs	13.8
Appeals Council	.3
Federal Court	.2

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[1] The data relate to workloads processed at various levels in fiscal year 1987, but include some cases where the initial level decision was made in a prior period. The data include determinations on initial applications as well as continuing disability reviews (both periodic reviews and medical diary cases).

[2] Title II only. Title XVI and concurrent Title II/XVI cessation go directly to an ALJ hearing.

[3] Includes ALJ decisions not appealed further by the claimant but reviewed by the Appeals Council on its "own motion" authority.

[4] Includes dismissals, denials of requests for review, and affirmations of denial.

[5] Initial determinations plus CDRs.

Source: Office of Disability, Social Security Administration.

TABLE 5.—ADMINISTRATIVE LAW JUDGE REVERSAL RATES—DISABILITY INSURANCE [1] INITIAL DENIALS AND TERMINATIONS,[2] FISCAL YEARS 1979–87

	Dismissed	Affirmed	Reversed	Total	Percent reversed
Fiscal year 1979:					
Initial denials	6,332	31,485	48,934	86,751	56.4
Terminations	1,401	4,078	8,052	13,531	59.5
Fiscal year 1980:					
Initial denials	7,093	31,703	56,733	95,529	59.4
Terminations	1,431	4,197	9,909	15,537	63.8
Fiscal year 1981:					
Initial denials	15,141	59,930	98,129	173,200	56.7
Terminations	2,623	6,945	16,685	26,253	63.6
Fiscal year 1982:					
Initial denials	15,403	67,481	91,865	174,749	52.6
Terminations	4,670	17,502	37,306	59,478	62.7
Fiscal year 1983:					
Initial denials	14,334	65,626	79,427	159,387	49.8
Terminations	9,247	37,284	73,821	120,352	61.3
Fiscal year 1984:					
Initial denials	15,075	63,381	88,301	166,757	53.0
Terminations	25,681	22,590	56,327	104,598	53.9
Fiscal year 1985:					
Initial denials	14,806	61,161	92,118	168,085	54.8
Terminations	4,176	2,415	3,126	9,717	32.2
Fiscal year 1986:					
Initial denials	28,792	44,223	78,737	151,752	51.9
Terminations	1,095	2,129	2,014	5,238	38.4
Fiscal year 1987:					
Initial denials	15,271	58,412	98,180	171,863	57.1
Terminations	812	1,954	2,014	4,780	42.1

[1] Includes title II and concurrent title II/title XVI disability cases and concurrent title II/title XVI aged cases.
[2] Includes all termination cases regardless of the basis for termination.

Source: Office of Hearings and Appeals, Social Security Administration.

Table 6 presents information on the number of continuing disability reviews—title II cases—that were conducted in fiscal years 1977–87. From fiscal year 1977 to 1981 the number of cases reviewed ranged from 2.4 percent to 4.9 percent of the total number of disabled persons on the Social Security rolls. With the administration's implementation of the provision of the 1980 disability amendments calling for more periodic reviews of eligibility, in 1981–83 the percent of cases reviewed rose sharply, reaching 13.5 percent of the caseload in 1983, the highest rate of review during the 11-year period. While the number of reviewed cases rose, the percent of cases terminated at the initial stage of review stayed fairly stable. The initial-stage termination rate during the 1977–83 period ranged from about 39 to 48 percent, and for the most part hovered in the range of 45 to 48 percent. Thus, the number of terminations rose sharply beginning in 1981 as the case-review workload mounted, peaking at 182,000 in 1983. This was more than four times the number of annual initial-stage terminations that occurred during the 1977-80 period. A sharp decline in the number of reviews occurred in 1984 and 1985, reflecting the Secretary's moratorium on reviews pending enactment of the 1984 disability legislation and the subsequent delay in implementing the legislation. Only a little more than 3,000 cases were reviewed in 1985 and less than 2,800 initial-stage terminations were rendered.

With the reimplementation of the review process in the spring of 1986, the number of cases subjected to reexamination began rising again. More than 45,000 cases were reviewed in 1986 and 164,000 cases in 1987. The percent of the disability rolls reviewed in 1987 reached 4.8 percent, a level almost as high as was reached in 1981 and considerably higher than the levels of the 1977-80 period. In contrast to those earlier years, however, the rate of termination under the new review procedures has thus far been much lower. Only 5.6 percent of the cases reviewed in 1986 were terminated and only 12.4 percent in 1987, far lower than the 39-47 percent termination rate of the 1977-80 period. Consequently, while the number of cases being reviewed now appears to be relatively high, the number of initial-stage terminations is much lower than in the 1977-80 period. It is yet unclear whether the 1987 case-review workload is indicative of future ongoing levels, and whether a higher or lower termination rate can be expected with future reviews. However, the administration has announced that it is budgeting for a similar number of reviews in fiscal year 1988.

TABLE 6.—CONTINUING DISABILITY REVIEWS (CDR) INITIAL DECISIONS: TITLE II DISABLED WORKERS, DISABLED WIDOWS AND WIDOWERS, AND DISABLED CHILDREN CESSATIONS AND CONTINUATIONS, FISCAL YEARS 1977-87

	Cessations		Continuations		Total cases		
	Number	Percent	Number	Percent	Cessations and continuations	Total disabled persons	Percent reviewed
1977	41,475	38.7	65,745	61.3	107,220	[1] 3,322,230	3.2
1978	38,847	46.4	44,804	53.6	83,651	3,447,767	2.4
1979	45,216	48.1	48,868	51.9	94,084	3,457,837	2.7
1980	44,273	46.8	50,227	53.2	94,550	3,454,010	2.7
1981	80,956	47.9	87,966	52.1	168,922	3,413,602	4.9
1982	179,857	44.8	221,325	55.2	401,182	3,263,354	12.3
1983	182,074	41.7	254,424	58.3	436,498	3,226,883	13.5
1984 [2]	31,927	24.6	97,752	75.4	129,679	3,249,367	4.0
1985 [2]	2,785	85.4	475	14.6	3,260	3,332,870	.1
1986	2,554	5.6	42,805	94.4	45,359	3,261,768	1.4
1987	20,343	12.4	143,712	87.6	164,055	3,433,524	4.8

[1] In current pay at end of fiscal year.

[2] The decline in the number of reviews in 1984 and 1985 was due to the national moratorium on reviews pending enactment and implementation of the new legislation with revised criteria for CDI's (enacted in 1984, regulations promulgated late 1985).

Source: Office of Disability Programs, Social Security Administration.

RECENT EXPERIENCE IN THE DISABILITY PROGRAM

After peaking at an all-time high in 1978, the number of beneficiaries on the DI rolls declined significantly from 4.868 million in 1978 to 3.813 million in December 1983. This was a decline of 21.7 percent. The number of awards declined from 592,049 in 1975 to approximately 298,531 in 1982. Awards increased in 1985 (377,371) and 1986 (416,865) and declined slightly in 1987 (415,848). The incidence of disability (number of awards per 1,000 insured workers) fell from an all-time high of 7.1 in 1975 to 2.9 in 1982, the lowest incidence rate in the history of the program, and now stands at 3.8 for 1987. (See table 7.)

Table 8 shows the number of DI beneficiaries for selected years.

TABLE 7.—DISABLED WORKERS' APPLICATIONS, AWARDS AND RATIO OF AWARDS TO APPLICATIONS AND AWARDS PER 1,000 INSURED WORKERS FOR 1960, 1965, 1970 TO 1987

	Number of applications (in thousands)	Total awards	Total awards divided by total applications (percent)	Awards per 1,000 insured workers
1960	418.6	207,805	50	4.5
1965	532.9	253,499	48	4.7
1970	868.2	350,384	40	4.8
1971	924.4	415,897	45	5.6
1972	947.8	455,438	48	6.0
1973	1,066.9	491,616	46	6.3
1974	1,330.2	535,977	40	6.7
1975	1,285.3	592,049	46	7.1
1976	1,232.2	551,460	45	6.5
1977	1,235.2	568,874	46	6.5
1978	1,184.7	464,415	39	5.2
1979	1,187.8	416,713	35	4.4
1980	1,262.3	396,559	31	4.0
1981	1,161.3	345,254	30	3.4
1982	1,020.0	298,531	29	2.9
1983	1,017.7	311,491	31	3.0
1984	1,035.7	357,141	34	3.4
1985	1,066.2	377,371	35	3.5
1986	1,118.4	416,865	37	3.8
1987	1,109.1	415,848	37	3.8

Source: Office of the Actuary, Social Security Administration.

TABLE 8.—NUMBER OF DISABILITY INSURANCE BENEFICIARIES FOR SELECTED YEARS: 1960–87

[Current payment status, December]

	Disabled workers	Spouses	Children	Total
Year:				
1960	455,371	76,599	155,481	687,451
1965	988,074	193,362	557,615	1,739,051
1970	1,492,948	283,447	888,600	2,664,995
1975	2,488,774	452,922	1,410,504	4,352,200
1980	2,861,253	462,204	1,358,715	4,682,172
1981	2,776,519	428,212	1,251,543	4,456,274
1982	2,603,713	365,883	1,003,869	3,973,465
1983	2,568,966	308,060	935,904	3,812,930
1984	2,596,535	303,984	921,285	3,821,804
1985	2,656,500	305,528	945,141	3,907,169
1986	2,727,386	300,592	965,301	3,993,279
1987	2,785,885	290,895	967,944	4,044,724

Source: Office of Research and Statistics, Social Security Administration.

Tables 9 through 11 present data on the demographic, social, and medical characteristics of the disabled population over time. For instance, Table 9 shows the increase in the receipt of benefits by women, which reflects larger societal trends in female workforce participation. Table 10 indicates the higher levels of educational attainment that characterize the present disabled population in comparison to that of 1970.

CHARACTERISTICS OF DI BENEFICIARIES

TABLE 9.—PERCENT DISTRIBUTION BY AGE AND SEX OF DISABLED WORKER BENEFICIARIES ALLOWED BENEFITS IN SELECTED YEARS 1970–87, COMPARED WITH ADULT U.S. POPULATION

Characteristics	Year allowed benefits							Adult U.S. population [1]
	1970	1975	1979	1982	1985	1986	1987	
Total percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Age:								
Under 35	9.0	11.0	13.6	14.4	16.8	17.2	17.1	49.0
35 to 44	11.0	10.0	11.5	12.3	15.0	16.0	16.0	19.0
45 to 54	26.0	26.0	27.2	26.5	25.7	22.7	22.9	16.0
55 to 59	24.0	23.0	27.0	27.2	23.9	21.4	20.8	8.0
60 and over	30.0	30.0	20.6	19.6	18.7	22.7	23.2	8.0
Median age (years)	56.0	55.6	53.4	53.1	51.7	53.0	53.0	35.4
Sex:								
Male	74	68	69	70	67	67	66	49
Female	26	32	31	30	33	33	34	51

[1] Derived from 1980 Census; based on population aged 18–64.

Source: Office of Disability, Social Security Administration.

TABLE 10.—PERCENT DISTRIBUTION BY EDUCATION AND OCCUPATION OF DISABLED WORKER BENEFICIARIES ALLOWED BENEFITS IN SELECTED YEARS 1970–87, COMPARED WITH ADULT U.S. POPULATION

Education and occupation	Year allowed benefits							Adult U.S. population [1]
	1970	1975	1979	1982	1985	1986	1987	
Total percent	100	100	100	100	100	100	100	100
Education (years of school completed):								
No schooling	2	1	1	1	[2] 2	[3] 1	[4] 1	2
Elementary school (1 to 8)	44	37	29	26	23	21	18	17
High school	46	52	55	56	59	59	57	51
9 to 11	23	24	23	22	22	21	19	14
12	23	28	32	34	37	38	38	37
Some college	9	10	12	14	14	15	16	32
Unknown	0	0	3	3	2	5	8	2
Occupation:								
Professional, technical and managerial	12	18	14	14	NA	NA	29	24
Clerical and sales	15	14	15	15	NA	NA	11	25
Service	18	17	15	14	NA	NA	18	12
Farming	6	4	4	3	NA	NA	2	3
Transportation, packaging and handling, mineral extraction	14	12	12	12	NA	NA	5	18
Machine trades	11	10	10	10	NA	NA	4	
Bench work	6	7	6	5	NA	NA	4	
Processing	3	3	3	4	NA	NA	3	18
Structural work	15	15	14	15	NA	NA	6	
Unknown	0	0	7	8	NA	NA	18	

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[1] Derived from 1980 Census. Figures for education based on persons aged 25 and over. Figures for occupation based on employed population aged 18–64.

[2] Special schools for handicapped (1.2 percent) and no schooling (0.7 percent).

[3] Special schools for handicapped (0.3 percent) and no schooling (0.6 percent).

[4] Special schools for handicapped (0.3 percent) and no schooling (0.5 percent).

Source: Office of Disability, Social Security Administration.

NA—Not available.

TABLE 11.—PERCENT DISTRIBUTION BY DISABLING CONDITION AND MOBILITY OF DISABLED WORKER BENEFICIARIES ALLOWED BENEFITS IN SELECTED YEARS 1970–87

Disabling condition and mobility	Year allowed benefits					
	1970	1975	1979	1982	1985	1987
Total percent	100	100	100	100	100	100
Disabling condition:						
Infective and parasitic diseases	3	1	1	1	1	1
Neoplasms	10	10	14	17	15	12
Allergic, endocrine system, metabolic and nutritional diseases	4	3	3	4	5	5
Mental, psychoneurotic and personality disorders	11	11	11	11	18	23
Diseases of the nervous system and sense organs	6	7	8	9	8	8
Circulatory system	31	32	28	25	19	17
Respiratory system	7	7	6	7	5	5
Digestive system	3	3	2	2	2	1
Skeletal musculo	15	17	17	16	13	14
Accidents, poisonings and violence	8	6	6	6	4	5
Other/unknowns	2	3	3	2	11	9
Mobility:						
Institutionalized	6	2	2	1	2	3
Hospitalized	6	3	2	3	2	1
Housebound	6	2	2	2	2	1
Ambulatory outside house:						
With help	16	13	10	10	10	4
By self	66	77	82	81	83	90
Other/unknown	0	0	2	3	2	[1] 0

[1] Other/unknown excluded. Mobility not obtained for most of the year.

Source: Office of Disability, Social Security Administration.

RECENT LEGISLATIVE CHANGES

98TH CONGRESS: THE DISABILITY BENEFITS REFORM ACT OF 1984

Public Law 98-460, the Disability Benefits Reform Act of 1984, made several substantial changes in the standards for review of disability beneficiaries, and in other provisions of the program as well. The following is a summary of the law.

1. Medical improvement standard

Public Law 98-460 established a medical improvement standard under which the Secretary may terminate disability benefits on the basis that the person is no longer disabled only if:

(1) There is substantial evidence demonstrating that (a) there has been any medical improvement in the individual's impairment or combination of impairments (other than medical improvement which is not related to the person's ability to work),

(b) the individual is now able to engage in substantial gainful activity (SGA); or

(2) There is substantial evidence consisting of new medical evidence and a new assessment of RFC which demonstrates that although there is no medical improvement, (a) the person has benefited from advances in medical or vocational therapy or technology related to ability to work, and (b) that he or she is now able to perform SGA; or

(3) There is substantial evidence that although there is no medical improvement (a) the person has benefited from vocational therapy and (b) the beneficiary can now perform SGA; or

(4) There is substantial evidence that, based on new or improved diagnostic techniques or evaluations, the person's impairment or combination of impairments is not as disabling as it was considered to be at the time of the prior determination, and that therefore the individual is able to perform SGA; or

(5) There is substantial evidence either in the file at the original determination or newly obtained showing that the prior determination was in error; or

(6) There is substantial evidence that the original decision was fraudulently obtained; or

(7) If the individual is engaging in SGA (except where he or she is eligible under Section 1619), fails without good cause to cooperate in the review or follow prescribed treatment or cannot be located.

In making the determination, the Secretary was required to consider the evidence in the file as well as any additional information concerning the claimant's current or prior condition secured by the Secretary or provided by the claimant.

Determinations under this provision had to be made on the basis of the weight of the evidence, and on a neutral basis with regard to the individual's condition, without any inference as to the presence or absence of disability based on the previous finding of disability.

Effective date: Applied only with respect to the following categories:

(1) Determinations by the Secretary made after the date of enactment;

(2) Cases pending at any level of the administrative process on the date of enactment;

(3) Cases of individual litigants pending in Federal court on the date the conference report was filed;

(4) Cases of named plaintiffs in class action suits pending on that date;

(5) Cases of unnamed plaintiffs in class action suits certified prior to that date; and

(6) Cases where a request for judicial review was made on a decision of the Secretary made during the 60 days preceding enactment;

Cases in categories (3), (4), (5), and (6) had to be remanded to the Secretary for review under this standard. Individuals in (5) were to be sent a notice via certified mail informing them that they had 120 days after the date of receipt of the notice to request a review under the medical improvement standard.

No class action could be certified after the date the conference report was filed which raised the issue of medical improvement with respect to an individual whose benefits were terminated prior to that date.

Persons whose cases were remanded to the Secretary were to receive benefits pending the Secretary's decision and appeal of that decision if they so elected. If found eligible, any person whose case was remanded under this provision was to receive benefits retroactive to the date they were last found ineligible.

2. Evaluation of pain

The Secretary of HHS was required, in conjunction with the National Academy of Sciences, to conduct a study concerning the questions of using subjective evidence of pain in determining whether a person is under a disability, and the state of the art of preventing, reducing or coping with pain. This study was completed and a report was submitted to the House Committee on Ways and Means and the Senate Committee on Finance in 1986. While making many recommendations, it basically supported the existing treatment of allegations of pain in disability determinations.

The provision also established a statutory standard for considering pain which was in effect until December 31, 1986:

> An individual's statement as to pain or other symptoms shall not alone be conclusive evidence of disability as defined in this section; there must be medical signs and findings, established by medically acceptable clinical or laboratory diagnostic techniques which show the existence of a medical impairment that results from anatomical, physiological or psychological abnormalities which could reasonably be expected to produce the pain or other symptoms alleged and which, when considered with all evidence required to be furnished under this paragraph (including statements of the individual or his physician as to the intensity and persistence of such pain or other symptoms which may reasonably be accepted as consistent with the medical signs and findings), would lead to a conclusion that the individual is under a disability. Objective medical evidence of pain or other symptoms established by medically acceptable clinical or laboratory techniques (for example, deteriorating nerve or muscle tissue), must be considered in reaching a conclusion as to whether the individual is under a disability.

3. Multiple impairments

In determining whether a person's impairment or impairments are of a sufficient medical severity to be the basis of a finding of eligibility for benefits, the Secretary was required to consider the combined effect of all of the person's impairments, whether or not any one impairment would alone be severe enough to qualify the person for benefits. The provision became effective for all determinations made on or after 30 days after enactment.

4. Moratorium on mental impairment reviews

A moratorium was imposed on reviews of all cases of mental impairment disability until the mental impairment criteria in the Listing of Impairments were revised to realistically evaluate the person's ability to engage in SGA in a competitive workplace environment. The moratorium applied to all cases on which an administrative or judicial appeal was pending on or after June 7, 1983. All persons claiming benefits based on mental impairment disability who received an unfavorable initial or continuing disability decision after March 1, 1981 were permitted to reapply for benefits within 12 months of enactment. The revised criteria were published in 1985.

5. Pretermination notice

The Secretary was required to initiate demonstration projects on providing face-to-face interviews for (1) pretermination continuing disability cases and (2) for all initial denial cases, in lieu of face-to-face evidentiary hearings at reconsideration, to be done in at least five States with a report due to the Committees on Ways and Means and Finance on April 1, 1986. The Secretary was also required to notify individuals, upon initiating a periodic eligibility review, that termination of benefits could be the result of the review, and that medical evidence may be provided. Although these studies have been completed, the report has not yet been submitted to Congress.

6. Continuation of benefits during appeal

This provision provided for continuation of benefits during appeal for all continuing disability review cases through the decision of the administrative law judge, at the election of the individual. Where the ALJ's decision is adverse to the individual, these benefits were to be repaid. The provision was made permanent for SSI disability recipients, and applied to DI beneficiaries through December 1987. The 1987 Omnibus Budget Reconciliation Act extended the provision for another year for DI beneficiaries.

7. Qualifications of medical professionals

This provision required the Secretary to make every reasonable effort, in cases based on mental impairments, to insure that a qualified psychiatrist or psychologist completes the medical portion of the case review and of the residual functional capacity assessment before any determination is made that an individual is not disabled. The Secretary was given the authority to contract directly for such services if the State agency is unable to do so.

8. Standards for consultative examinations/medical evidence

The Secretary was required to promulgate regulations regarding consultative examinations, including when they should be obtained, the type of referral to be made, and the procedures for monitoring the referral process. Further, the Secretary was required to make every effort to obtain necessary medical evidence from the treating physician before evaluating medical evidence from any other source, and to consider all evidence in the case record and development of complete medical history over at least the preceding 12-month period.

9. Administrative procedure and uniform standards

As required, regulations were published setting forth uniform standards for DI and SSI disability determinations under section 553 of the Administrative Procedure Act, to be binding at all levels of adjudication.

10. Nonacquiescence

While the conference agreement dropped both the House and Senate provisions relating to the Secretary's acquiescence with Court rulings, the intent was not to endorse the practice of "nonacquiescence." The conferees noted that questions had been raised about the constitutional basis of the practice, that many of the conferees had strong concerns about the practice, and that a policy of nonacquiescence should be followed only where steps have been taken or are intended to be taken to receive a review of the disputed issue in the Supreme Court. The conferees also urged the Secretary to seek a resolution of the nonacquiescence issue in the Supreme Court.

11. Payment of costs of rehabilitation services

The provision permitted reimbursement to State agencies for costs of VR services provided to individuals receiving DI benefits under section 225(b) of the Social Security Act who medically recover while in VR, whether or not the person worked at SGA for 9 months, and whether or not the person failed to cooperate in the program.

12. Direction for Quadrennial Social Security Advisory Council

The provision required the next quadrennial advisory council (as required in the Social Security Act) to study the medical and vocational aspects of disability using ad hoc panels of experts where appropriate. The study was to include alternative approaches to work evaluation for SSI recipients, effectiveness of VR programs, and other disability program policies, standards, and procedures. The Council was appointed and met regularly over the past year. The report is expected early in 1988.

13. Staff attorneys

The Secretary was to report, within 120 days of enactment, to the Committees on Ways and Means and Finance, on the actions taken by the Secretary to establish positions which enable staff attorneys to gain the qualifying experience and quality of experience necessary to compete for ALJ positions. Statement of managers stated that it was assumed, given OPM actions at the time, that statutory requirements for establishing specific positions were not required, and the Secretary was urged to take all reasonable steps to see that the OPM actions resulted in SSA staff attorneys becoming qualified for GS-15 ALJ positions.

14. SSI benefits for persons working despite impairment

This provision extended Sections 1619 (a) and (b) through June 30, 1987, and required the Secretaries of HHS and Education to establish training programs for staff personnel in SSA district offices and State VR agencies, and disseminate information to SSI applicants, recipients, and potentially interested public and private organizations. Sections 1619 (a) and (b) were made permanent in 1986.

15. Frequency of continuing eligibility reviews

The Secretary was required to promulgate regulations establishing standards for determining the frequency of continuing eligibility reviews. Final regulations were to be issued within 6 months and during that period no individual could be subjected to more than one periodic review.

16. Representative payees for Social Security and SSI beneficiaries

The Secretary was required to (1) evaluate qualifications of prospective payees prior to or within 45 days following certification, (2) establish a system of annual accountability monitoring where payments are made to someone other than a parent or spouse living in the same household with the beneficiary, and (3) report to Congress on implementation, and annually on the number of cases of misused funds and disposition of such cases.

TABLE 12.—ESTIMATED OUTLAYS RESULTING FROM THE MAJOR PROVISIONS IN PUBLIC LAW 98-460, THE SOCIAL SECURITY DISABILITY BENEFITS REFORM ACT OF 1984

[By fiscal year, in millions of dollars]

	1985	1986	1987	1988	1989
Termination of benefits based on medical improvement:					
DI	86	123	130	136	133
HI and SMI	25	35	40	40	40
Medicaid	3	4	4	4	4
SSI	3	4	4	4	4
Multiple impairments:					
DI	4	7	11	13	15
HI and SMI	(1)	(1)	1	2	2
Medicaid	(1)	1	1	1	1
SSI	1	2	2	3	3
Continued payment during appeal:					
DI	149	134	114	60	−20
HI and SMI	48	50	40	15	0
Medical personnel qualifications:					
DI	(1)	(1)	10	10	20
HI and SMI	(1)	(1)	1	1	3
Medicaid	(1)	(1)	1	1	2
SSI	(1)	(1)	2	2	5
Vocational rehabilitation:					
DI	2	4	7	8	8
HI and SMI	(1)	(1)	(1)	(1)	(1)
SSI	(1)	(1)	(1)	(1)	(1)
Extension of sections 1619a and 1619b:					
Medicaid	10	7	6	0	0

TABLE 12.—ESTIMATED OUTLAYS RESULTING FROM THE MAJOR PROVISIONS IN PUBLIC LAW 98-460, THE SOCIAL SECURITY DISABILITY BENEFITS REFORM ACT OF 1984—Continued

[By fiscal year, in millions of dollars]

	1985	1986	1987	1988	1989
SSI	1	2	2	0	0
Total:					
DI [2]	220	243	247	216	140
HI and SMI	73	85	82	58	45
Medicaid	13	12	12	6	7
SSI	5	8	10	9	12
Total outlays [2]	311	348	351	289	204

[1] Less than $500,000.

[2] The details do not add to the totals due to interaction between provisions.

Note: Preliminary estimates.

Source: Congressional Budget Office.

LEGISLATIVE CHANGES IN THE 1ST SESSION OF THE 100TH CONGRESS

Three disability insurance provisions were included in Public Law 100-203, the Budget Reconciliation Act of 1987:

1. Continuation of benefits during appeal.—The existing provision for continued payment of disability benefits during the administrative appeal process was extended for 1 additional year.

2. Lengthening of the extended period of eligibility for disability benefits.—The extended period of eligibility during which a disability beneficiary who returns to work may become automatically reentitled to benefits, was lengthened from the current 15 months to 36 months. Medicare eligibility is not continued beyond the period provided under current law.

3. Payment of attorneys' fees.—The administrative policy which permits ALJ's to authorize attorneys' fees of up to $3,000 without approval by an SSA regional office was reinstated.

Section 3. Social Security Financing

OVERVIEW

This section presents an overview of the financing of the old-age, survivors, and disability insurance (OASDI) trust funds, and provides a summary of the short- and long-term projections for the financial solvency of these funds under a variety of demographic and economic assumptions.

CURRENT LAW FINANCING

The Social Security programs (OASDHI) are financed through the payroll tax and from income taxes paid on Social Security benefits on a pay-as-you-go basis; that is, most of current income to the system goes out directly to meet current benefit obligations. Any funds collected in excess of the amount needed to make benefit payments are credited to the trust funds as reserves, in the form of Government securities. These reserves serve as a cushion against temporary shortfalls in revenues or large increases in outlays due to economic fluctuations; the reserves also provide interest income to the trust funds. As a result of the Social Security Amendments of 1983, OASDI reserves are projected to build rapidly in the next quarter century.

Trust fund income is dependent on the amount of wages covered by Social Security on which taxes are levied according to the payroll tax rate for each year. Benefit outlays are made under a permanent appropriation, in the amount to which beneficiaries are entitled based on their earnings records, and are not limited to the amount of revenue credited to the trust fund from contributions and interest. If, as has occurred in the early part of the decade, yearly income is insufficient to cover benefit payments, reserves are used to make up the difference.

The payroll tax is levied on earnings in employment covered by social security, with portions of the total tax rate allocated by law to each of the three trust funds (OASI, DI and HI). All persons who work in covered employment pay this mandatory tax on their earnings up to a maximum dollar amount (known as the contribution and benefit base, or earnings base). Employers pay an equal tax rate for these workers. Beginning in 1984 self-employed workers pay social security taxes that are equivalent to the combined employer-employee rate and receive a partial credit against that tax through 1989. The self-employment credit expires at the end of 1989, but beginning in 1990 self-employment taxes will be computed on a lower base and half of the tax will be deductible for income tax purposes. Under current law, as of January 1988, the tax paid by both the employer and employee is 7.51 percent of the first $45,000 of earnings (self-employed persons pay 13.02 percent). Another increase in the tax rates is set in the law to become effective in 1990 (to 7.65 percent for employers and employees). Increases in the earnings base are automatic, based on the increase in average wages in the economy (excluding self-employment earnings) each year.[1] Table 1 summarizes the payroll tax schedule both historically and under the provisions of current law.

TABLE 1.—SELECTED PAYROLL TAX RATE AND WAGE BASE LEVELS, HISTORICALLY AND UNDER CURRENT LAW

	Wage base	Contribution rate (percent) employer/employee each			
		Total	OASI	DI	HI
1937	$3,000	1.0	1.0	....	....
1950	3,000	1.5	1.5	....	....
1955	4,200	2.0	2.0	....	....
1959	4,800	2.5	2.25	0.25	....
1966	6,600	4.2	3.5	.35	0.35
1970	7,800	4.8	3.65	.55	.60
1974	13,200	5.85	4.375	.575	.90
1978	17,700	6.05	4.275	.775	1.00
1979	22,900	6.13	4.33	.75	1.05
1981	29,700	6.65	4.70	.65	1.30
1982	32,400	6.70	4.575	.825	1.30
1984	37,800	[1] 7.00	5.20	.50	1.30
1985	39,600	7.05	5.20	.50	1.35
1986	42,000	7.15	5.20	.50	1.45
1987	43,800	7.15	5.20	.50	1.45
1988	45,000	7.51	5.53	.53	1.45
1989	(2)	7.51	5.53	.53	1.45
1990–99	(2)	7.65	5.60	.60	1.45
2000 and after	(2)	7.65	5.49	.71	1.45

[1] A tax credit of 0.3 percent of taxable wages was allowed against the tax paid by employees, so that the effective employee withholding rate for 1984 was 6.7 percent.

[2] Subject to automatic increase.

Source: Social Security Bulletin, Annual Statistical Supplement, 1987, Table D.

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[1] They are triggered whenever cost-of-living adjustments are granted to Social Security beneficiaries and are effective on a calendar year basis.

TABLE 2.—CURRENT LAW SOCIAL SECURITY PAYROLL TAX RATES FOR SELF-EMPLOYED INDIVIDUALS, BY INDIVIDUAL AND COMBINED TRUST FUNDS, 1980 AND AFTER

Calendar year	OASI	DI	OASDI combined	HI	OASDHI combined
1980	6.2725	0.7775	7.05	1.05	8.10
1981	7.0250	0.9750	8.00	1.30	9.30
1982	6.8125	1.2375	8.05	1.30	9.35
1983	7.1125	0.9375	8.05	1.30	9.35
1984	10.4000	1.0000	11.40	2.60	[1] 14.00
1985	10.4000	1.0000	11.40	2.70	[1] 14.10
1986–87	10.4000	1.0000	11.40	2.90	[1] 14.30
1988–89	11.0600	1.0600	12.12	2.90	[1] 15.02
1990–99	11.2000	1.2000	12.40	2.90	15.30
2000 and after	10.9800	1.4200	12.40	2.90	15.30

[1] Excludes tax credits, which equalled 2.7 percent in 1984, 2.3 percent in 1985, and 2.0 percent for the years 1986 through 1989.

Source: Social Security Bulletin, Annual Statistical Supplement, 1987, Table D.

In 1940, approximately 24 million persons worked in employment covered by the social security system. Over the years, major categories of workers were brought under the system, such as State and local government employees (on a voluntary basis), regularly employed farm and domestic workers, members of the armed services, and self-employed professionals such as physicians and lawyers. In 1982, over 116 million workers and 95 percent of all jobs in the United States were covered under social security. The present law social security earnings base, as revised by the 1977 Amendments and updated automatically according to wage increases in the economy, provides that about 90 percent of all covered earnings are taxable.

While coverage is compulsory for most types of employment, approximately 8 million jobs were exempt from coverage under social security prior to 1984. The majority of these noncovered positions were and still are in the Federal Government and in State and local governments. Beginning January 1, 1983, Federal employees were covered under the Medicare portion of the Social Security tax, and as of January 1, 1984, all new Federal employees are covered under the OASDI portion as well. About 70 percent of State and local government jobs (10 million out of 14.6 million jobs), and about 80 percent of nonprofit organization jobs were covered by Social Security as of 1981. Beginning January 1, 1984, all employees of nonprofit organizations became covered, and terminations of Social Security coverage by State government entities were no longer allowed.[2] As of April 1, 1986, all newly hired State and local employees are mandatorily covered under the Medicare program and must pay HI payroll taxes. Table 4 shows State-by-State data on State and local government jobs covered in 1984.

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[2] Terminations were prohibited as of April 1983.

TABLE 3.—SOCIAL SECURITY COVERAGE, 1984

[In millions]

Occupational group	Number of employees	Covered [1]	
		Number	Percent
Specifically exempt from OASI coverage:			
Federal Civilian employees	3.9	0.9	[2] 23.1
Voluntary coverage:			
State and local government	14.6	10.0	68.7
Mandatorily covered:			
Industry and commerce	82.1	81.9	99.8
Nonprofit [3]	6.8	6.8	100.0
Farm [3]	1.9	1.6	84.0
Domestic [3]	1.6	.5	29.5
Self-employed [3]	9.2	7.0	76.0

[1] Data on covered employment are estimated based upon class of worker of major job in which employed over the year 1984.

[2] Federal employees who are temporary or who work for quasi-Federal agencies such as TVA are covered. The 1983 Social Security Amendments covered Federal employees hired after 1983, as well as all nonprofit employees, current and future.

[3] Mandatorily covered if special minimum coverage requirements met. Special minimum requirements for coverage generally relate to amount of wages earned—for example, domestic employees must receive at least $50 from one employer during a calendar quarter for those wages to be covered.

Source: Office of Research and Statistics, Social Security Administration.

TABLE 4.—ESTIMATES OF SOCIAL SECURITY COVERAGE OF WORKERS WITH STATE AND LOCAL GOVERNMENT EMPLOYMENT AS THEIR MAJOR JOB IN 1984 [1]

[Numbers in thousands]

State	All workers	Covered workers	Percent covered
Total	14,531	9,985	69
Alabama	245	218	89
Alaska	58	18	31
Arizona	182	161	89
Arkansas	145	127	87
California	1,563	572	37
Colorado	197	47	24
Connecticut	170	107	63
Delaware	41	27	66
Florida	597	470	79
Georgia	351	287	82
Hawaii	72	48	67
Idaho	64	64	100
Illinois	626	327	52
Indiana	320	266	83
Iowa	199	194	98

TABLE 4.—ESTIMATES OF SOCIAL SECURITY COVERAGE OF WORKERS WITH STATE AND LOCAL GOVERNMENT EMPLOYMENT AS THEIR MAJOR JOB IN 1984 [1]—Continued

[Numbers in thousands]

State	All workers	Covered workers	Percent covered
Kansas	167	165	99
Kentucky	210	154	73
Louisiana	320	49	15
Maine	74	22	29
Maryland	288	259	90
Massachusetts	334	0	0
Michigan	534	515	96
Minnesota	291	195	67
Mississippi	156	154	99
Missouri	286	224	78
Montana	64	59	91
Nebraska	118	116	98
Nevada	52	3	6
New Hampshire	55	49	90
New Jersey	475	445	94
New Mexico	120	87	73
New York	1,278	1,122	88
North Carolina	394	351	89
North Dakota	55	49	90
Ohio	595	0	0
Oklahoma	223	190	85
Oregon	184	170	93
Pennsylvania	590	554	94
Rhode Island	58	33	57
South Carolina	208	202	97
South Dakota	52	50	95
Tennessee	248	219	88
Texas	971	485	50
Utah	102	101	99
Vermont	35	34	98
Virginia	391	319	82
Washington	285	249	87
West Virginia	128	121	94
Wisconsin	309	261	84
Wyoming	51	46	90

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[1] Major job is determined by type of employment of longest job (all workers) and of job with largest amount of covered wages (covered workers).

Source: Office of Research and Statistics, Social Security Administration.

CURRENT SHORT-RANGE STATUS OF THE TRUST FUNDS

An assessment of the short-range status of the trust funds depends heavily on the economic assumptions underlying the estimates, because both the revenues and expenditures of the program are tremendously affected by general economic trends such as unemployment, wage growth, and inflation. Tables 5 and 6 present short-term projections of the financial status of the trust funds under the assumptions contained in the President's fiscal year 1989 budget and the Congressional Budget Office baseline, respectively.

TABLE 5.—CURRENT LAW PROJECTIONS OF THE OLD-AGE AND SURVIVORS INSURANCE AND DISABILITY INSURANCE TRUST FUND OUTLAYS, INCOMES, AND BALANCES ON THE BASIS OF THE PRESIDENT'S FISCAL YEAR 1989 BUDGET ASSUMPTIONS

[By fiscal year, in billions of dollars]

	Fiscal year—						
	1987	1988	1989	1990	1991	1992	1993
Old-age and survivors insurance:							
Total outlays	186.1	197.8	210.8	224.7	238.6	251.2	263.2
Income [1]	206.8	234.2	254.9	278.3	301.7	323.3	347.0
Year-end balance	58.3	94.7	138.8	192.4	255.5	327.6	411.4
Start-of-year balance as percent of outlays [2]	27	37	53	69	88	110	133
Disability insurance:							
Total outlays	21.2	22.2	23.2	24.3	25.5	26.9	28.2
Income [1]	20.0	22.2	24.1	28.2	31.5	33.7	36.2
Year-end balance	7.2	7.3	8.1	12.1	18.1	25.0	33.0
Start-of-year balance as percent of outlays [2]	45	39	38	40	55	76	97
Combined OASI and DI:							
Total outlays	207.3	219.9	234.0	249.0	264.1	278.0	291.4
Income [1]	226.9	256.5	279.0	306.5	333.2	357.0	383.2
Year-end balance	65.4	102.0	146.9	204.5	273.6	352.2	444.4
Start-of-year balance as percent of outlays	29	37	51	67	85	106	129

[1] Income to the trust funds is budget authority, and includes payroll tax receipts, interest on investments, and certain general fund transfers.

[2] Start-of-year balances for OASI and DI are computed as the balances at the end of the previous year plus advanced tax transfers at the beginning of the year.

Source: Social Security Administration, Office of the Actuary estimates based on President's fiscal year 1989 economic assumptions.

TABLE 6.—CURRENT LAW PROJECTIONS OF THE OLD-AGE AND SURVIVORS INSURANCE AND DISABILITY INSURANCE TRUST FUND OUTLAYS, INCOMES, AND BALANCES UNDER CBO'S BASELINE SET OF ECONOMIC ASSUMPTIONS

[By fiscal year, in billions of dollars]

	Fiscal year—						
	1987	1988	1989	1990	1991	1992	1993
Old-age and survivors insurance:							
Total outlays	186.8	198.0	211.8	227.7	243.2	258.7	274.4
Income[1]	207.5	234.8	256.4	281.8	308.1	332.8	363.0
Year-end balance	58.3	95.1	139.9	193.7	258.8	332.9	421.5
Start-of-year balance (as percent of outlays)[2]	28	38	53	69	88	108	132
Disability Insurance:							
Total outlays	21.3	22.0	23.3	24.7	26.2	27.8	29.5
Income[1]	20.1	22.7	24.4	28.8	32.1	34.7	37.9
Year-end balance	7.2	7.8	9.0	13.1	19.0	25.9	34.4
Start-of-year balance (as percent of outlays)[2]	46	40	41	45	59	77	97
Combined OASI and DI:							
Total outlays	208.1	220.0	235.0	252.3	269.4	286.5	303.9
Income[1]	227.6	257.5	280.8	310.6	340.2	367.6	400.9
Year-end balance	65.4	102.9	148.7	206.9	277.8	358.9	455.8
Start-of-year balance (as percent of outlays)[2]	30	38	52	68	86	108	129

[1] Income to the trust funds is budget authority, and includes payroll tax receipts, interest on investments, and certain general fund transfers.

[2] Start-of-year balance for OASI and DI are computed as the balances at the end of the previous year plus advanced tax transfers at the beginning of the year.

Source: Congressional Budget Office estimates based on February 1988 baseline economic assumptions.

Status of OASDI trust fund

Under the President's budget as well as CBO baseline assumptions, the combined OASDI trust funds will continue the growth begun in 1984 throughout the 5-year projection period incorporated in the President's and CBO's forecasts. The growth will accelerate during 1988 due to the increase in the OASDI portion of the FICA tax rates that become effective in January. Yearly increases in the OASDI trust fund balances (i.e., excess of revenues over benefit outlays) will continue to increase, reaching almost $100 billion per year by 1993. Throughout the 1990's, and for some period into the next century, the favorable demographic pattern of a large baby-boom generation at peak earning years combined with the retirement of the relatively small generation born during the depression should insure large trust fund reserves.

For the combined OASDI funds, under the President's budget assumptions, the trust fund reserve ratio is estimated to increase from 29 percent at the beginning of 1987 to 37 percent for 1988, and then increase each year thereafter, reaching 51 percent by 1989 and 129 percent by 1993. A similar pattern of increase is shown under the CBO baseline assumptions. This increase includes, in the balance at the beginning of each fiscal year, the tax receipts for October which are to be transferred on the first day of the month under the provision for advance transfer of taxes to the trust funds.

Budgetary treatment of OASDI trust funds

The Balanced Budget and Emergency Deficit Control Act of 1985 contains two provisions dealing with the budgetary treatment of the OASDI trust fund operations. The Act amended the Social Security Act to provide that the operations of the OASDI trust funds, scheduled to be taken off-budget beginning in fiscal year 1993 under the 1983 Amendments, would be taken off-budget beginning with fiscal year 1986. The Act also required, however, that the operations of the OASDI trust funds be taken into account as part of the budget in determinations having to do with calculation of the maximum deficit amount under the Balanced Budget Act. The effect of these two provisions is to effectively continue to include the OASDI trust fund operations in the Federal budget for purposes of meeting the maximum deficit amount targets throughout the 5 years in which the Balanced Budget Act is in effect.[3]

The result is that the surpluses generated in the OASDI system are included in calculating the amount of revenue or spending reduction needed to meet the mandatory targets. These surpluses, according to the President's Budget will range from about $45 billion in fiscal year 1989 to around $92 billion in fiscal year 1993. Without inclusion of the trust funds in the budget for this purpose, at least $45 billion more would have to be found either through revenue increases or spending reductions to meet the $136 billion target mandated by law for fiscal year 1989.

It should be noted that the continuance of Social Security surpluses (income exceeding outgo) could have a favorable effect on the overall financing of the Federal Government long after the Social Security trust funds are officially removed from the Federal budget. Excess Social Security receipts are deposited in the General Treasury, and while they would cause the reserves (i.e., the Federal securities) of the trust funds to rise, they would make more resources available to the Government. With all other things held constant, they would reduce the amount of public borrowing the Government must do to function. This reduction could take the form of less "new borrowing" in face of continuing budget deficits or an actual retirement of a portion of the outstanding Federal debt held by the public. On the other hand, the surplus receipts could be used for additional spending (that would not otherwise occur) or to offset other tax levies. In either of these cases, Government borrowing from the public would not be reduced. Ultimately, the use of the excess receipts will be determined by future fiscal policy decisions.

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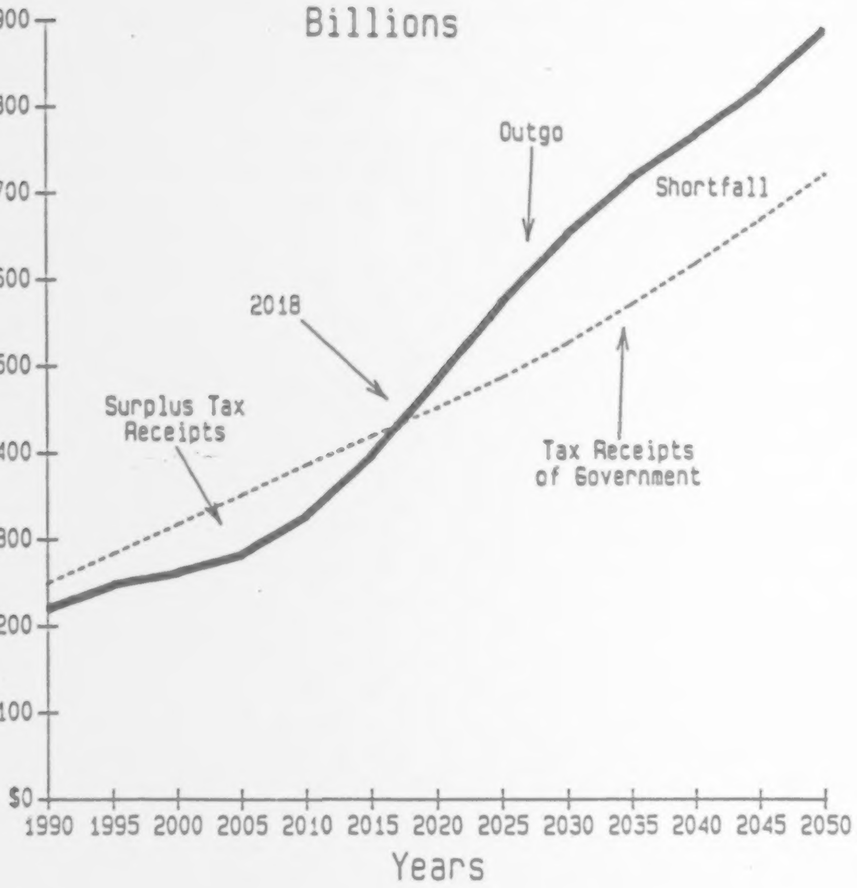
[3] The Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987 amended the 1985 Act and extended the period in which it would be effective from fiscal year 1991 to fiscal year 1993.

Receipts and Expenditures of Government for Social Security In Constant 1986 Dollars



Long Range Status of the Trust Funds

OASDI trust funds

Because the Social Security program has been designed as a contributory system in which those who pay the taxes supporting it are considered to be earning the right to future benefits, Congress has traditionally required long-range estimates of the program's actuarial balance and has set future tax rates with a view to assuring that the income of the program will be sufficient to cover its outgo. Under current procedures, the long-range actuarial analysis of the cash benefits program covers a 75-year period—this would generally be long enough to cover the anticipated retirement years of those currently in the work force.

The long-range status of the Social Security trust funds is ordinarily expressed in terms of "percent of taxable payroll" rather than in dollar amounts. This permits a direct comparison between the tax rate actually in the law and the cost of the program. For example, if the program is projected to have a deficit of "1 percent of taxable payroll," this means that the Social Security tax rates now in the law would have to be increased by 0.5 percent points for employee and employer, each, in order to pay for the benefits due under present law. (Alternatively, the program could be brought back into balance by an equivalent reduction in benefit outgo or by a combination of revenue increases and outgo reductions.) If the program is projected to have a deficit of 1.5 percent of taxable payroll and expenditures are projected to be 10 percent of taxable payroll, then, under the given set of assumptions, 15 percent (1.5 divided by 10) of expenditures could not be met with that tax schedule. In 1987, the total taxable payroll amounted to approximately $2.0 trillion so that in 1987 terms, 1.5 percent of payroll represented about $29 billion.

In the short range, the financial soundness of each of the trust funds can be assessed by considering the size of the trust fund balance, in absolute terms and as a percentage of the annual expenditures, and whether the balance is growing or declining. In the long range, the traditional measure of financial soundness has been the actuarial balance of the system. The actuarial balance is defined as the difference between the total income rate and the total cost rate. If the average income rate is between 95 percent and 105 percent of the average cost rate, over the 75-year long-range projection period, the system is said to be in close actuarial balance.

The long-range financial condition of the Social Security programs will be determined by three types of long-range factors: demographic factors such as rates of fertility, life expectancy, and labor force participation which determine how many workers there will be in the society in relation to nonworking beneficiaries; economic factors such as unemployment, productivity, and inflation; and Social Security program factors, such as benefit levels, total number of covered workers, and percent of eligible workers drawing early retirement benefits.

In projecting the long-term condition of the OASDI trust funds, the actuaries at the Social Security Administration employ four sets of alternative economic and demographic assumptions. Alternative I is based on optimistic assumptions, alternatives II–A and II–B on moderate assumptions, and alternative III on pessimistic assumptions. In general, alternative II–B is considered the most balanced estimate of long-term solvency.

It is clear that these factors cannot be predicted with any certainty as far into the future as 75 years, and the long-range projections should not be taken as absolute predictions of deficits or surpluses in the funds.

Table 7 shows a comparison of the estimated cost rate with the estimated income rate for selected years from 1986 through 2060. The income rate is the sum of the scheduled tax rate and the income from taxation of benefits expressed as a percentage of taxable payroll. On the basis of the 1987 alternative II–B assumptions, estimated income will exceed the estimated cost of the program through the second decade of the next century. After the year 2018, income from scheduled payroll taxes and from the taxation of benefits will not be large enough to cover estimated annual costs, although the accumulated trust fund balance is projected to be sufficient to allow the program to continue operating satisfactorily for many years. The average actuarial balances are estimated to be a surplus of 2.1 percent of taxable payroll for the first 25 years of the long-range projection period and a deficit of 1.22 percent for the second 25 years. The surplus is offset by an estimated deficit of 2.74 percent of taxable payroll in the third 25-year period of the 75-year projection period.

Table 8 shows the estimates of OASI and DI trust fund ratios for each year from 1981 through 2060. As a percent of annual expenditures, the combined assets of the OASI and DI trust funds are estimated to grow until the latter part of the second decade in the next century, reaching levels of about 545 percent of annual expenditures in 2015. Thereafter, the combined trust fund ratios decline steadily to less than 50 percent by 2049.

The trust fund ratio for OASI exhibits a similar pattern—increasing to about 613 percent in the second decade of the next century and declining thereafter to less than 50 percent by 2054. The DI trust fund increases to about 236 percent of annual expenditures by the first decade of the next century and declines to exhaustion by the year 2025.

TABLE 7.—ESTIMATED LONG-RANGE OASDI ANNUAL INCOME RATE, COST RATE, AND ACTUARIAL BALANCE UNDER THE PROGRAM BASED ON ALTERNATIVE II–B OF THE 1987 TRUSTEES' REPORTS

[Percent of taxable payroll]

Year	Income rate			Cost rate			Balance [1]		
	OASI	DI	OASDI	OASI	DI	OASDI	OASI	DI	OASDI
1987	10.57	1.01	11.58	9.79	1.10	10.89	+.78	−.09	+.69
1988	11.23	1.07	12.30	9.82	1.08	10.90	+1.41	.00	+1.41
1989	11.24	1.07	12.32	9.88	1.07	10.95	+1.36	+.01	+1.37
1990	11.42	1.22	12.64	9.92	1.06	10.98	+1.50	+.16	+1.66
1991	11.40	1.21	12.62	9.92	1.05	10.97	+1.49	+.17	+1.65
1992	11.41	1.21	12.63	9.88	1.04	10.92	+1.53	+.17	+1.71
1993	11.42	1.22	12.63	9.86	1.04	10.90	+1.56	+.17	+1.73
1994	11.42	1.22	12.63	9.84	1.05	10.89	+1.58	+.17	+1.75
1995	11.42	1.22	12.64	9.82	1.06	10.87	+1.60	+.16	+1.76
1996	11.42	1.22	12.64	9.79	1.06	10.85	+1.63	+.15	+1.78
1997	11.42	1.22	12.64	9.67	1.08	10.76	+1.75	+.13	+1.88
1998	11.43	1.22	12.65	9.49	1.11	10.60	+1.94	+.11	+2.05
1999	11.44	1.22	12.66	9.32	1.13	10.45	+2.12	+.09	+2.21
2000	11.22	1.45	12.67	9.15	1.16	10.31	+2.07	+.29	+2.36
2001	11.23	1.45	12.68	9.00	1.19	10.19	+2.23	+.26	+2.49
2002	11.24	1.45	12.69	8.87	1.22	10.09	+2.37	+.23	+2.60
2003	11.25	1.46	12.70	8.76	1.26	10.01	+2.49	+.20	+2.69
2004	11.25	1.46	12.71	8.66	1.30	9.96	+2.59	+.16	+2.75
2005	11.26	1.46	12.72	8.59	1.35	9.94	+2.67	+.11	+2.79
2006	11.28	1.47	12.74	8.48	1.40	9.88	+2.79	+.07	+2.86
2007	11.28	1.47	12.75	8.52	1.45	9.97	+2.76	+.02	+2.78
2008	11.28	1.47	12.76	8.60	1.50	10.10	+2.69	−.03	+2.66
2009	11.29	1.47	12.76	8.71	1.55	10.26	+2.58	−.07	+2.50
2010	11.30	1.48	12.77	8.87	1.58	10.46	+2.43	−.11	+2.32
2011	11.31	1.48	12.78	9.05	1.62	10.67	+2.26	−.14	+2.12
2015	11.35	1.48	12.84	10.02	1.72	11.75	+1.33	−.24	+1.09
2020	11.43	1.49	12.92	11.62	1.81	13.43	−.19	−.32	−.51
2025	11.50	1.49	12.99	13.03	1.90	14.93	−1.53	−.41	−1.94
2030	11.55	1.50	13.05	13.97	1.87	15.83	−2.41	−.37	−2.78
2035	11.58	1.50	13.08	14.26	1.81	16.06	−2.67	−.31	−2.98
2040	11.60	1.50	13.09	14.10	1.80	15.90	−2.51	−.30	−2.81
2045	11.60	1.50	13.11	13.91	1.85	15.77	−2.31	−.35	−2.66
2050	11.61	1.50	13.11	13.93	1.87	15.80	−2.32	−.37	−2.69
2055	11.61	1.50	13.11	14.01	1.86	15.87	−2.40	−.36	−2.76
2060	11.61	1.50	13.11	14.02	1.84	15.85	−2.41	−.33	−2.74
2065	11.61	1.50	13.11	14.02	1.84	15.86	−2.41	−.34	−2.75
25-year averages:									
1987–2011	11.30	1.32	12.61	9.29	1.22	10.51	+2.01	+.10	+2.10
2012–2036	11.47	1.49	12.96	12.37	1.81	14.18	−.90	−.32	−1.22
2037–2061	11.60	1.50	13.10	14.00	1.84	15.85	−2.40	−.34	−2.74
75-year average:									
1987–2061	11.46	1.44	12.89	11.89	1.63	13.51	−.43	−.19	−.62

[1] A positive balance indicates a surplus; a negative balance indicates a deficit.

Source: Office of the Actuary, Social Security Administration.

TABLE 8.—ESTIMATED LONG-RANGE OASI AND DI TRUST FUND RATIOS

[In percent]

Year	OASI	DI	OASDI	Year	OASI	DI	OASDI
1981	18	21	18	2021	567	57	500
1982	15	17	15	2022	554	39	487
1983	15	14	14	2023	540	20	472
1984	20	35	21	2024	524	(1)	457
1985	24	27	24	2025	508	(1)	[2] 441
1986	28	38	29	2026	492	(1)	[2] 424
1987	30	44	31	2027	474	(1)	[2] 407
1988	40	40	40	2028	456	(1)	[2] 390
1989	55	41	53	2029	438	(1)	[2] 373
1990	69	45	67	2030	420	(1)	[2] 356
1991	85	61	83	2031	403	(1)	[2] 338
1992	102	78	100	2032	385	(1)	[2] 321
1993	119	95	117	2033	367	(1)	[2] 304
1994	136	113	134	2034	350	(1)	[2] 287
1995	154	129	152	2035	333	(1)	[2] 270
1996	172	144	169	2036	317	(1)	[2] 254
1997	192	156	189	2037	301	(1)	[2] 237
1998	215	166	210	2038	285	(1)	[2] 221
1999	240	173	233	2039	270	(1)	[2] 205
2000	268	178	258	2040	254	(1)	[2] 189
2001	295	197	284	2041	239	(1)	[2] 174
2002	324	213	310	2042	224	(1)	[2] 158
2003	354	225	338	2043	209	(1)	[2] 142
2004	387	232	367	2044	194	(1)	[2] 126
2005	420	236	395	2045	179	(1)	[2] 111
2006	457	236	425	2046	164	(1)	[2] 95
2007	488	233	451	2047	149	(1)	[2] 79
2008	517	227	473	2048	134	(1)	[2] 63
2009	541	219	493	2049	118	(1)	[2] 47
2010	562	211	509	2050	102	(1)	[2] 30
2011	580	201	522	2051	87	(1)	[2] 14
2012	594	189	533	2052	71	(1)	(1)
2013	604	177	540	2053	54	(1)	(1)
2014	611	165	544	2054	38	(1)	(1)
2015	613	151	545	2055	22	(1)	(1)
2016	611	137	543	2056	5	(1)	(1)
2017	607	122	538	2057	(1)	(1)	(1)
2018	600	107	531	2058	(1)	(1)	(1)
2019	591	90	522	2059	(1)	(1)	(1)
2020	580	74	512	2060	(1)	(1)	(1)

[1] The fund is projected to be exhausted.

[2] Because the DI fund is exhausted, these ratios are theoretical and are shown for information purposes only.

Note: The above estimates are based on the 1987 alternative II–B assumptions. The trust fund ratio is defined as the ratio of the trust fund balance at the beginning of the year to the outgo during the year. After 1983, ratios reflect the inclusion of advance tax transfers for January. These estimates reflect the repayment in 1986 of the remainder ($10.6 billion) of the $12.4 billion borrowed by OASI from HI in 1982.

ECONOMIC AND DEMOGRAPHIC ASSUMPTIONS

The following tables provide specific information concerning the economic and demographic assumptions which underlie the Social Security trustees' short and long-run financial projections.

TABLE 9.—ECONOMIC ASSUMPTIONS, 1960–2060

Calendar year	Average annual percentage increase in—				
	Real GNP [1]	Average wages in covered employment	Consumer Price Index [2]	Real-wage differential [3] (percent)	Average annual unemployment rate [4] (percent)
Past experience:					
1960–64	3.9	3.4	1.3	2.1	5.7
1965–69	4.2	5.4	3.4	2.0	3.8
1970–74	2.4	6.3	6.1	.2	5.4
1975	−1.3	6.7	9.1	−2.5	8.5
1976	4.9	8.5	5.7	2.8	7.7
1977	4.7	7.2	6.5	.7	7.1
1978	5.3	9.6	7.6	2.0	6.1
1979	2.5	9.2	11.4	−2.2	5.9
1980	−.2	9.1	13.5	−4.4	7.2
1981	1.9	9.3	10.3	−1.0	7.6
1982	−2.5	[5] 6.6	6.0	[5] .6	9.7
1983	3.6	[5] 5.0	3.0	[5] 2.0	9.6
1984	6.4	[5] 5.9	3.4	[5] 2.4	7.5
1985	2.7	[5] 4.1	3.5	[5] .6	7.2
Alternative II–B:					
1986	2.6	3.8	1.6	2.3	7.0
1987	2.3	4.3	3.2	1.1	7.1
1988	3.0	5.2	4.5	.7	7.1
1989	2.9	5.2	4.3	.8	6.9
1990	3.0	5.8	4.5	1.3	6.6
1991	3.0	5.9	4.3	1.6	6.2
1992	2.6	5.6	4.0	1.6	6.0
1993	2.3	5.4	4.0	1.4	5.9
1994	2.3	5.5	4.0	1.5	5.9
1995	2.3	5.4	4.0	1.4	5.8
1996	2.3	5.6	4.0	1.6	5.8
2000	2.1	5.6	4.0	1.6	6.0
2010 and later	[6] 1.7	5.5	4.0	1.5	6.0
Pessimistic:					
1986	2.5	3.3	1.6	1.7	7.0
1987	−1.2	2.6	3.4	−.9	7.9
1988	1.2	5.2	5.4	−.3	9.0
1989	1.8	5.8	6.0	−.2	8.5
1990	−.3	5.0	5.7	−.7	9.6
1991	3.7	6.8	5.0	1.8	8.7
1992	2.4	5.9	5.0	.9	8.2
1993	2.2	5.8	5.0	.8	7.8

TABLE 9.—ECONOMIC ASSUMPTIONS, 1960–2060—Continued

Calendar year	Average annual percentage increase in—				
	Real GNP [1]	Average wages in covered employment	Consumer Price Index [2]	Real-wage differential [3] (percent)	Average annual unemployment rate [4] (percent)
1994	2.2	6.0	5.0	1.0	7.4
1995	2.2	5.9	5.0	.9	7.1
1996	2.1	6.1	5.0	1.1	6.9
2000	1.5	6.1	5.0	1.1	7.0
2010 and later	[6] 1.2	6.0	5.0	1.0	7.0

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[1] The real GNP (gross national product) is the total output of goods and services, expressed in 1982 dollars.

[2] The Consumer Price Index is the average of the 12 monthly values of the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI–W).

[3] The real-wage differential is the difference between the percentage increases, before rounding, in (1) average annual wages in covered employment, and (2) the average annual Consumer Price Index.

[4] Through 1996, the rates shown are crude civilian unemployment rates. After 1996, the rates are total rates (including military personnel), adjusted by age and sex based on the estimated total labor force on July 1, 1986.

[5] Preliminary.

[6] This value is for 2010. The annual percentage increase in real GNP is assumed to continue to change after 2010 for each alternative to reflect the dependence of labor force growth on the size and age-sex distribution of the population. The increases for 2060 are 3.1, 2.1, 1.7, and 0.5 percent for alternatives I, II–A, II–B, and III, respectively.

Source: Office of the Actuary, Social Security Administration.

TABLE 10.—MAJOR LONG-TERM DEMOGRAPHIC AND LABOR FORCE PARTICIPATION ASSUMPTIONS

[1987 trustees' report II-B assumptions]

FERTILITY RATES

	1917	1933	1947	1957	1976	1981	1995	2015+
Children born per woman in her lifetime	3.33	2.17	3.18	3.68	1.74	1.83	1.90	2.00

LIFE EXPECTANCIES

[Using mortality for calendar year]

	1900	1940	1960	1980	2000	2020	2060
Male:							
At birth	46.4	61.4	66.7	69.9	73.9	75.1	76.2
Age 65	11.4	11.9	12.9	14.0	15.6	16.3	17.0
Female:							
At birth	49.0	65.7	73.2	77.5	80.8	82.0	83.1
Age 65	12.0	13.4	15.9	18.4	20.1	21.0	21.9

PERCENTAGE OF THOSE BORN WHO CAN EXPECT TO REACH AGE 65

[Using mortality for calendar year]

	1900	1940	1960	1980	2000	2020	2060
Male	37.3	55.5	63.8	70.5	78.6	80.4	82.9
Female	41.0	65.4	78.2	83.4	87.3	88.5	90.1

LABOR FORCE PARTICIPATION RATES

[Age adjusted]

[In percent]

	1981	1985	1990	1995	2000	2060
Male	77.9	76.9	76.4	76.2	75.9	75.4
Female	52.1	54.6	57.6	58.7	58.3	57.3

COVERED WORK FORCE—NUMBER OF BENEFICIARIES AND DEPENDENCY RATES

	1960	1980	2000	2020	2040
Total population (in millions)	190	235	275	304	316
Covered workers	73	113	143	147	146
Beneficiaries	14	35	44	64	78
Dependency ratio [1]	.904	.753	.672	.728	.842
Worker/beneficiary ratio	5.1	3.2	3.3	2.3	1.9

[1] Ratio of nonworking age to working-age population—population under 20 plus population 65 and over divided by population 20–64.

PERCENT OF ELIGIBLE WORKERS [1] DRAWING RETIREMENT BENEFITS

	1980	1990	2000	2010	2020	2030 [2]
62–64:						
Male	38.5	47.0	47.1	43.0	41.3	39.4
Female	60.7	63.9	61.3	55.3	53.2	51.4
65–69:						
Male	90.6	90.0	87.1	79.9	79.1	75.6
Female	95.5	91.1	87.9	80.8	80.6	77.6

[1] Includes all retired-worker beneficiaries and those widow(er) beneficiaries who would be retired-worker beneficiaries if they filed claims.

[2] For years beyond 2030 (the last year of phase-in to normal retirement age of 67), the figures show only small fluctuations.

SENSITIVITY OF LONG-TERM PROJECTIONS

Long-range estimates of the financial status of the OASDI trust funds are extremely sensitive to the basic social, economic, and demographic variables that underpin the projections. Slight variations in assumptions about future demographic or economic trends can lead to substantially different financial projections, and thus any longer term estimate is necessarily very uncertain. In general terms, the income to the funds crucially depends on long-run trends in covered wages paid to employees, which in turn depends on many fundamental economic and demographic factors, such as real wage growth in the economy, fluctuations in the size of the work force, productivity, and overall rates of fertility and immigration. The expenditures of the program depend on the amount of benefits that are paid, which is of course affected by the level of consumer inflation, changes in mortality rates and life expectancy, disability incidence, and work and retirement patterns among the elderly population.

As a way of illustrating the sensitivity of long-term projections to variations in basic assumptions, table 11 presents data on the effects of varying assumptions about real wage growth in the alternative II–B estimates. As the table shows, the assumption that real wage growth will equal 1.0 percent leads to a long-range deficit of 1.43 percent of taxable payroll, as compared to real wage growth of 2.5 percent, which would yield a long-term surplus of 0.80 percent of taxable payroll. This table is based on the premise that all other alternative II-B demographic and economic assumptions are held constant. (Under alternative II-B, the real wage growth assumption is 1.5 percent.)

TABLE 11.—ESTIMATED OASDI AVERAGE INCOME RATES, COST RATES, AND BALANCES, BASED ON ALTERNATIVE II-B WITH VARIOUS REAL-WAGE ASSUMPTIONS

[As a percentage of taxable payroll]

Calendar years	Ultimate percentage increase in wages-CPI [1]			
	5.0-4.0	5.5-4.0	6.0-4.0	6.5-4.0
Average income rate:				
1987-2011	12.62	12.61	12.60	12.59
2012-2036	13.00	12.96	12.93	12.90
2037-2061	13.16	13.10	13.05	13.01
1987-2061	12.93	12.89	12.86	12.83
Average cost rate:				
1987-2011	10.87	10.51	10.17	9.85
2012-2036	15.13	14.18	13.31	12.52
2037-2061	17.08	15.85	14.73	13.73
1987-2061	14.36	13.51	12.74	12.03
Balance:				
1987-2011	+1.75	+2.10	+2.43	+2.75
2012-2036	−2.13	−1.22	−.39	+.38
2037-2061	−3.92	−2.74	−1.68	−.72
1987-2061	−1.43	−.62	+.12	+.80

[1] The first value in each pair is the assumed ultimate annual percentage increase in average wages in covered employment. The second value is the assumed ultimate annual percentage increase in the Consumer Price Index. The difference between the two values is the real-wage differential.

Source: 1987 Trustee's Report.

Tables 12 and 13 provide information on the effects of varying two other key assumptions in estimating long-term financial solvency. Table 12 shows the impact of choosing among alternative assumptions of the ultimate total fertility rate in the general population. As the table demonstrates, a total fertility rate of 1.6 percent leads to a long-run deficit of 1.72 percent of taxable payroll, while a 2.3 percent fertility rate generates a 0.03 percent of taxable payroll surplus. The middle estimate, 2.0 percent, is employed in the alternative II-B projections.

TABLE 12.—ESTIMATED OASDI AVERAGE INCOME RATES, COST RATES, AND BALANCES, BASED ON ALTERNATIVE II–B WITH VARIOUS FERTILITY ASSUMPTIONS

[As a percentage of taxable payroll]

Calendar years	Ultimate total fertility rate [1]		
	1.6	2.0	2.3
Average income rate:			
1987–2011	12.61	12.61	12.61
2012–2036	12.99	12.96	12.94
2037–2061	13.25	13.10	13.02
1987–2061	12.95	12.89	12.85
Average cost rate:			
1987–2011	10.48	10.51	10.53
2012–2036	14.79	14.18	13.78
2037–2061	18.77	15.85	14.18
1987–2061	14.67	13.51	12.82
Balance:			
1987–2011	+2.13	+2.10	+2.08
2012–2036	−1.80	−1.22	−.84
2037–2061	−5.52	−2.74	−1.16
1987–2061	−1.72	−.62	+.03

[1] The total fertility rate for any year is the average number of children who would be born to a woman in her lifetime if she were to experience the birth rates by age observed in, or assumed for, the selected year, and if she were to survive the entire child-bearing period. The ultimate total fertility rate is assumed to be reached in 2010.

Source: 1987 Trustee's Report.

Table 13 displays the effects of varying the death-rate assumptions in the alternative II–B estimate. The assumption that the age-sex-adjusted death rate will drop by 22 percent over the period 1985 through 2060 leads to a 0.02 percent deficit in taxable payroll in the long run, while a 58 percent drop in the death rate produces a long-range taxable payroll deficit of 1.49 percent of taxable payroll. The baseline death-rate assumption under alternative II–B is 38 percent.

TABLE 13.—ESTIMATED OASDI AVERAGE INCOME RATES, COST RATES, AND BALANCES, BASED ON ALTERNATIVE II-B WITH VARIOUS DEATH-RATE ASSUMPTIONS

[As a percentage of taxable payroll]

Calendar years	Reduction in death rates [1]		
	22 percent	38 percent	58 percent
Average income rate:			
1987–2011	12.60	12.61	12.61
2012–2036	12.93	12.96	13.00
2037–2061	13.05	13.10	13.19
1987–2061	12.86	12.89	12.93
Average cost rate:			
1987–2011	10.35	10.51	10.67
2012–2036	13.57	14.18	14.96
2037–2061	14.73	15.85	17.64
1987–2061	12.88	13.51	14.42
Balance:			
1987–2011	+2.25	+2.10	+1.94
2012–2036	−.64	−1.22	−1.97
2037–2061	−1.68	−2.74	−4.45
1987–2061	−.20	−.62	−1.49

[1] The measure of the reduction in death rates is the decrease in the age-sex-adjusted death rate during 1985–2061.

Source: 1987 Trustee's Report.

Similar, though less drastic, variations occur when assumptions related to net immigration, inflation, disability incidence, and other factors are modified. This sensitivity underscores the uncertainty of long-term financial estimates.

APPENDIX A. STATISTICAL HISTORY AND FUTURE BENEFIT PROJECTIONS OF THE SOCIAL SECURITY PROGRAMS

The Social Security Act of 1935 was signed into law on August 14, 1935. The immediate origin of this legislation was the Committee on Economic Security which had been charged by President Roosevelt with the task of devising safeguards "against misfortune which cannot be wholly eliminated in the man-made world of ours."

In addition to the Federal old-age retirement program (title II), the original Social Security Act also included grants-in-aid to States for: old-age pensions based on need (title I); unemployment compensation systems (title III); aid to dependent children (title IV); maternal and child welfare services, care of crippled children (title V), and and public health work (title VI).

The original act has been amended on numerous occasions since 1935. However, the most significant changes to title II were made by the Social Security Amendments of 1939, 1950, 1954, 1956, 1965, 1972, 1977, and 1983. In addition, the medicare (title XVIII) program was added to the Social Security Act in 1965.

Today the term "Social Security" is seldom used to refer to all of the programs included in the Social Security Act. The term is most often used to refer to either solely title II, the old-age and survivor program insurance program and, since 1956, the disability insurance program, or to both title II and to title XVIII, the Medicare program. This appendix presents historical data concerning the coverage, benefits and financing of each of the three programs.

COVERAGE

The original Social Security Act provided coverage on a mandatory basis under the old-age insurance program of all employees in commerce and industry (except railroad) under age 65. Specifically excluded from coverage "due to difficulties in collecting the tax" were the following services: agricultural labor; domestic services in a private home; casual labor not in the course of the employer's trade or business; and services performed by an officer or member of a crew on a documented vessel. Also specifically excluded were services performed in the employ of: the United States Government, a State or any political subdivision of a State; and nonprofit (including religious) organizations.

Coverage has been extended both on a mandatory and a voluntary basis. Mandatory coverage was extended to workers age 65 and over not otherwise excluded in 1939. In 1950 non-farm self-employed, regularly employed farm and domestic workers, and Federal civilian employees not under a retirement system were covered on a mandatory basis. In addition, the 1950 amendments provided elective coverage to State and local government employees not under a retirement system and employees of nonprofit organizations.

The most significant extensions of coverage provided by the 1954 amendments were to self-employed farmers on a mandatory basis and, on an elective basis, State and local government employees (except firemen and policemen) under retirement systems and ministers. Coverage was extended to members of the uniformed services in 1956, and to ministers and members of religious orders who do not choose to be exempt on religious grounds. In 1983, coverage was extended on a compulsory basis to the following major groups: Federal employees hired after December 31, 1983; current and future Members of Congress; the President and Vice President; Federal judges; and all employees of nonprofit organizations.

Effective in 1983, Federal civilians are covered under the Hospital Insurance portion of the Medicare program. Medicare coverage was also extended on a mandatory basis to State and local government employees hired after April 1, 1986. States are permitted to extend Medicare coverage (without extending coverage under Social Security cash benefits) to employees hired prior to April 1986 by voluntary agreement with the Secretary.

The following two tables detail the extension of coverage under the Social Security program in terms of both jobs and wages:

TABLE 1.—CIVILIAN WORKERS COVERED BY SOCIAL SECURITY SYSTEM, 1939–86

[In millions]

Year	Paid civilian employees [1]	OASDI coverage	Percent covered	OASDHI coverage	Percent covered
1939 [2]	43.6	24.0	55.1	24.0	55.1
1944 [2]	51.2	30.8	60.2	30.8	60.2
1949 [2]	56.7	34.3	60.5	34.3	60.5
1954 [2]	59.5	45.3	76.1	45.3	76.1
1955	62.8	51.8	82.5	51.8	82.5
1956	63.2	53.2	84.2	53.2	84.2
1957	63.1	53.7	85.1	53.7	85.1
1958	62.7	53.4	85.2	53.4	85.2
1959	64.4	55.4	86.0	55.4	86.0
1960	64.6	55.7	86.2	55.7	86.2
1961	65.3	56.1	85.9	56.1	85.9
1962	66.4	57.3	86.3	57.3	86.3
1963	67.6	58.5	86.5	58.5	86.5
1964	69.3	60.1	86.7	60.1	86.7
1965	71.6	62.7	87.6	62.7	87.6
1966	73.6	64.9	88.2	64.9	88.2
1967	74.4	65.7	88.3	65.7	88.3
1968	75.9	67.1	88.4	67.1	88.4
1969	78.0	68.6	87.9	68.6	87.9

TABLE 1.—CIVILIAN WORKERS COVERED BY SOCIAL SECURITY SYSTEM, 1939–86—Continued

[In millions]

Year	Paid civilian employees [1]	OASDI coverage	Percent covered	OASDHI coverage	Percent covered
1970	77.8	69.9	89.9	69.9	89.9
1971	79.6	71.7	90.1	71.7	90.1
1972	82.6	74.7	90.4	74.7	90.4
1973	85.6	77.6	90.6	77.6	90.6
1974	85.4	77.3	90.5	77.3	90.5
1975	86.0	77.9	90.6	77.9	90.6
1976	89.2	81.0	90.9	81.0	90.9
1977	93.5	85.1	91.0	85.1	91.0
1978	97.0	88.4	91.2	88.4	91.2
1979	99.4	90.7	91.3	90.7	91.3
1980	99.2	90.4	91.1	90.4	91.1
1981	99.0	90.2	91.1	90.2	91.1
1982	98.3	89.8	91.4	89.8	91.4
1983	102.2	93.6	91.6	96.0	94.0
1984	105.5	97.9	92.7	100.3	95.0
1985	107.7	100.0	92.9	102.4	95.1
1986	110.2	102.6	93.0	105.0	95.2

[1] Includes paid employees and self-employed for all years.

[2] Monthly average for these years; all other years as of December.

Source: Social Security Annual Statistical Supplement, 1982, and Office of Research and Statistics.

TABLE 2.—CIVILIAN WAGES COVERED BY OASDI SYSTEM, 1946–86 [1]

[Dollars in billions]

Year	Total earnings	Earnings in covered employment		Total covered earnings	Percent of total earnings covered	Taxable earnings	Percent of covered earnings
		Employed	Self-employed				
1946	$148.3	$79.3	....	$79.3	53.5	$69.1	87.1
1947	158.6	92.4	....	92.4	58.3	78.4	84.8
1948	176.0	102.3	....	102.3	58.1	84.1	82.2
1949	170.6	100.0	....	100.0	58.6	81.8	81.8
1950	186.1	109.8	....	109.8	59.0	87.5	79.7
1951	215.6	132.5	$16.4	148.9	69.1	120.8	81.1
1952	230.1	143.5	16.4	159.9	69.5	128.6	80.5
1953	242.4	156.0	17.0	173.0	71.4	135.9	78.5
1954	240.7	155.1	16.8	171.9	71.4	133.5	77.7

TABLE 2.—CIVILIAN WAGES COVERED BY OASDI SYSTEM, 1946–86 [1]—Continued

[Dollars in billions]

Year	Total earnings	Earnings in covered employment		Total covered earnings	Percent of total earnings covered	Taxable earnings	Percent of covered earnings
		Employed	Self-employed				
1955	257.4	171.6	24.5	196.1	76.2	157.5	80.3
1956	276.0	188.5	28.3	216.8	78.6	170.7	78.8
1957	288.8	205.5	28.4	233.9	81.0	181.4	77.5
1958	292.8	208.0	28.5	236.5	80.8	180.7	76.4
1959	311.5	225.1	29.9	255.0	81.9	202.3	79.3
1960	324.9	236.0	29.2	265.2	81.6	207.0	78.1
1961	334.8	240.7	30.0	270.7	80.9	209.6	77.4
1962	355.9	257.7	31.3	289.0	81.2	219.1	75.8
1963	372.4	270.6	31.7	302.3	81.2	225.6	74.6
1964	398.2	290.9	33.6	324.5	81.5	236.4	72.8
1965	428.8	311.4	40.3	351.7	82.0	250.7	71.3
1966	469.8	346.7	44.0	390.7	83.2	312.5	80.0
1967	500.1	377.5	44.8	422.3	84.4	330.0	78.1
1968	547.4	413.6	46.4	460.0	84.0	375.8	81.7
1969	597.6	455.7	47.1	502.8	84.1	402.6	80.1
1970	631.7	483.6	48.0	531.6	85.2	415.6	78.2
1971	671.2	509.0	50.7	559.7	83.4	427.0	76.3
1972	737.0	563.3	54.6	617.9	83.8	484.1	78.3
1973	827.7	624.4	62.3	686.7	83.0	561.9	81.8
1974	891.0	681.6	65.2	746.7	83.8	636.8	85.3
1975	940.1	717.2	70.4	787.6	83.8	664.7	84.4
1976	1,037.2	797.2	76.8	874.7	84.3	737.7	84.3
1977	1,146.9	883.1	80.7	963.8	84.0	816.0	84.7
1978	1,295.8	1,002.2	93.7	1,095.9	84.6	917.8	83.7
1979	1,443.9	1,125.0	100.2	1,225.2	84.9	1,073.9	87.7
1980	1,552.6	1,230.5	97.7	1,328.2	85.5	1,175.8	88.5
1981	1,697.1	1,348.2	98.9	1,447.1	85.3	1,293.0	89.4
1982 [2]	1,761.7	1,425.1	98.6	1,523.7	86.5	1,364.7	89.6
1983 [2]	1,867.1	1,501.6	109.3	1,610.9	86.3	1,454.2	90.3
1984 [2]	2,073.5	1,662.0	117.2	1,779.2	85.8	1,608.4	90.4
1985 [2]	2,231.9	1,779.2	126.4	1,905.6	85.4	1,721.9	90.4
1986 [2]	2,379.0	1,889.2	139.0	2,038.2	85.7	1,847.7	90.7

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[1] Sum of wages and salaries and proprietors' income with inventory valuation and capital consumption adjustments, as estimated by the Bureau of Economic Analysis in the National Income and Product Accounts.

[2] Preliminary.

Source: Social Security Bulletin, Annual Statistical Supplement, 1983, and Office of Research and Statistics.

TABLE 3.—NUMBER OF WORKERS AND AVERAGE EARNINGS UNDER OASDI, 1937–1986

Year	Workers with taxable earnings [1]	With maximum earnings	Average earnings per worker	
			Total earnings [2]	Reported taxable [2]
1937	32,900	1,031	$979	$900
1938	31,820	933	896	833
1939	33,750	1,055	954	881
1940	35,390	1,196	1,009	932
1941	40,980	1,866	1,110	1,021
1942	46,360	3,569	1,255	1,142
1943	47,660	5,942	1,462	1,310
1944	46,300	7,163	1,583	1,392
1945	46,390	6,361	1,543	1,357
1946	48,840	6,477	1,624	1,415
1947	48,910	9,620	1,890	1,602
1948	49,020	12,061	2,087	1,716
1949	46,800	11,740	2,137	1,748
1950	48,280	13,936	2,274	1,812
1951	58,120	14,270	2,562	2,078
1952	59,580	16,606	2,684	2,159
1953	60,840	19,013	2,844	2,233
1954	59,610	18,866	2,884	2,240
1955	65,200	16,704	3,008	2,416
1956	67,610	19,236	3,207	2,525
1957	70,590	21,095	3,314	2,569
1958	69,770	21,328	3,390	2,590
1959	71,700	19,112	3,556	2,822
1960	72,530	20,310	3,656	2,854
1961	72,820	21,265	3,717	2,879
1962	74,280	23,154	3,891	2,949
1963	75,540	24,570	4,002	2,986
1964	77,430	26,717	4,191	3,053
1965	80,680	29,136	4,359	3,108
1966	84,600	20,498	4,618	3,694
1967	87,040	22,948	4,852	3,791
1968	89,380	19,120	5,147	4,205
1969	92,060	22,577	5,462	4,373
1970	93,090	24,224	5,711	4,464
1971	93,340	26,404	5,996	4,574
1972	96,240	24,074	6,420	5,030
1973	99,830	20,250	6,879	5,628
1974	101,330	15,310	7,369	6,284
1975	100,200	15,070	7,860	6,633

TABLE 3.—NUMBER OF WORKERS AND AVERAGE EARNINGS UNDER OASDI, 1937–1986—Continued

Year	Workers with taxable earnings [1]	With maximum earnings	Average earnings per worker	
			Total earnings [2]	Reported taxable [2]
1976	102,600	15,330	8,525	7,190
1977	105,800	15,700	9,075	7,718
1978	110,600	17,050	9,823	8,278
1979	112,700	11,236	10,805	9,465
1980	113,000	9,903	11,742	10,396
1981	113,000	8,594	12,806	11,442
1982 [3]	112,600	7,978	13,516	12,113
1983 [3]	113,200	7,085	14,235	12,837
1984 [3]	118,850	7,513	14,995	13,527
1985 [4]	121,800	7,673	15,611	14,100
1986 [5]	124,200	7,825	16,243	14,726

[1] Relates to wage and salary workers for 1937–50. Beginning 1951, includes self-employment.

[2] Total wages, including estimated amounts above taxable limit, for 1937–50. Beginning 1951, also includes reported total net earnings of self-employed persons.

[3] Data subject to adjustment.

[4] Taxable earnings are preliminary estimates based on Social Security data; employment and total covered earnings are preliminary estimates based on data from Bureau of Labor Statistics and the National Income and Product Accounts.

[5] Preliminary estimates based on data from Bureau of Labor Statistics and the National Income and Product Accounts.

Source: Social Security Bulletin, Annual Statistical Supplement, 1987, Table 29.

BENEFITS

In order to be fully insured under the 1939 Amendments, a worker needed 2 quarters of coverage for each year elapsed since 1936 and before the quarter in which the worker died or turned 65. The minimum required for insured status was 6 quarters and the maximum was 40. The Social Security Amendments of 1950 significantly increased the number of workers who were insured for monthly benefits by requiring two quarters of coverage, which could be earned at any time, for each calendar year after 1950 or age 21, subject to the same maximum and minimum. The 1961 Amendments changed the requirement for fully insured status to only one quarter of coverage for each calendar year after 1950 or age 21. To be insured for disability benefits, under the 1956 amendments, a worker needed to have earned 6 quarters of coverage in the 13 quarters preceding disability (currently insured) and have earned 20 quarters of coverage in the 40 quarters preceding disability, in addition to being fully insured. The 1958 Amendments eliminated the currently insured status requirement. The 1967 Amendments liberalized the insured status requirement for disabled workers under age 31, which significantly increased the number of workers insured for disability beginning in 1969.

The 1935 Social Security Act provided monthly benefits to retired workers age 65 and over and a lump-sum death benefit to these workers. The monthly benefits were to first be paid beginning January 1, 1942. The 1939 Social Security Amendments provided benefits to dependents—wives aged 65 and over and children under age 16 (changed to 18 in 1946)—of retired workers, and to survivors—widows aged 65, mothers with eligible child in care, children under age 16, and dependent parents—of deceased workers. In addition the 1939 Amendments provided that these benefits first be paid in 1940.

Benefits that have been added in retirement and survivors programs since 1939 include: retired women aged 62–64 (1956); retired men aged 62–64 (1961); widows aged 60–64 (1956 and 1965); widowers aged 60 and over (1950, 1961, and 1972); and, disabled widows age 50 and over (1967, 1972, and 1977).

In 1956, benefits were extended to disabled workers aged 50–64 and to disabled children of retired, disabled, or deceased workers age 18 and over, if they became disabled prior to age 18. The 1958 Amendments provided benefits to dependents of disabled workers on the same basis as dependents of retired workers. Benefits for disabled workers under age 50 were provided in 1960.

Monthly cash benefits have been increased on an ad hoc basis 10 times prior to the first automatic cost-of-living adjustment which was incorporated in the act by the Social Security Amendments of 1972. Beginning with the 1975 increase, benefits have been automatically adjusted to keep pace with inflation. Since 1975, there have been increases annually except during calendar year 1983.

The following tables provide historical background concerning changes in insured status, benefit types, average amounts and increases, and OASDHI benefits paid:

TABLE 4.—ESTIMATED NUMBER OF PERSONS INSURED FOR OASDI, 1940–87 [1]

[In millions]

At beginning of year	Insured for retirement and/or survivor benefits					Workers insured in event of disability
	Total insured	Fully insured			Currently insured only	
		Total	Permanently insured	Not permanently insured		
1940	22.9	22.9	0.6	22.3	(2)	...
1941	24.9	24.2	1.1	23.1	0.7	...
1942	27.5	25.8	1.4	24.4	1.7	...
1943	31.2	28.1	1.8	26.3	3.1	...
1944	34.9	29.9	2.3	27.6	5.0	...
1945	38.6	31.9	2.8	29.1	6.7	...
1946	40.3	33.4	3.4	30.0	6.9	...
1947	41.8	35.4	8.6	26.8	6.4	...
1948	43.4	37.3	11.6	25.7	6.1	...
1949	44.8	38.9	13.2	25.7	5.9	...
1950	45.7	40.1	14.9	25.2	5.6	...
1951	59.8	59.8	21.0	38.8	(2)	...
1952	62.8	62.8	22.9	39.9	(2)	...
1953	68.2	68.2	25.6	42.7	(2)	...
1954	71.0	71.0	27.7	43.4	(2)	...
1955	70.6	70.2	29.9	40.4	.4	31.9
1956	71.4	70.5	32.5	38.0	.9	35.4
1957	74.3	74.0	36.1	38.0	.3	37.2
1958	77.0	76.1	38.3	37.9	.9	38.4
1959	78.9	76.5	40.3	36.2	2.4	43.4
1960	79.7	76.7	42.2	34.6	3.0	46.4
1961	85.4	84.4	47.6	36.8	1.0	48.5
1962	89.1	88.5	53.3	35.3	.5	50.5
1963	90.4	89.8	54.9	34.8	.6	51.5
1964	92.0	91.3	56.6	34.7	.8	52.3
1965	93.6	92.8	58.3	34.5	.9	53.3
1966	95.8	94.8	60.2	34.6	.9	55.0
1967	98.3	97.2	61.9	35.3	1.1	55.7
1968	101.2	99.9	63.3	36.6	1.3	56.9
1969	104.0	102.6	64.5	38.1	1.4	70.1
1970	106.5	105.0	65.7	39.4	1.5	72.4
1971	109.7	108.1	67.1	40.9	1.6	74.5
1972	112.3	110.6	68.3	42.3	1.7	76.1
1973	115.0	113.4	69.7	43.6	1.6	77.8
1974	118.1	116.5	71.0	45.5	1.6	80.4
1975	121.6	120.0	72.5	47.5	1.6	83.3

TABLE 4.—ESTIMATED NUMBER OF PERSONS INSURED FOR OASDI, 1940–87 [1]—Continued

[In millions]

At beginning of year	Insured for retirement and/or survivor benefits					Workers insured in event of disability
	Total insured	Fully insured			Currently insured only	
		Total	Permanently insured	Not permanently insured		
1976	124.5	122.9	74.1	48.8	1.6	85.3
1977	127.5	125.9	76.0	49.9	1.6	87.0
1978	130.4	128.9	78.0	50.9	1.5	89.3
1979	135.1	133.3	80.3	52.9	1.8	93.7
1980	138.7	137.0	82.6	54.4	1.7	98.0
1981	141.2	139.5	84.5	55.0	1.7	100.5
1982	144.1	142.4	87.6	54.9	1.7	102.4
1983	146.1	144.5	90.5	54.0	1.6	104.0
1984	147.4	145.9	93.5	52.5	1.5	104.9
1985	149.3	147.9	96.5	51.4	1.4	106.7
1986	151.6	150.3	99.7	50.6	1.3	108.8
1987	153.7	152.5	103.0	49.5	1.2	110.8

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[1] Estimated counts include those who have sufficient quarters of coverage to meet the eligibility requirements for retired-worker or disabled-worker benefits (including persons already receiving such benefits) or to permit the worker's spouse and children or survivors to establish eligibility for spouse's and children's or survivor's benefits in the event of his or her disability, retirement, or death. Beginning in 1966, transitionally insured persons are included with the permanently insured.

[2] Persons currently insured before July 1940, or currently insured after August 1950 and before July 1954, are also fully insured.

Source: Social Security Bulletin, Annual Statistical Supplement, 1987, Table 39.

TABLE 5.—PERCENT OF INSURED WORKERS AGED 62 AND OVER IN CURRENT PAYMENT STATUS, 1941–87 [1]

	Aged 62–64			Aged 65 and over		
	Male	Female	Total	Male	Female	Total
1941				20	25	20
1945				29	40	30
1950				59	61	59
1951				57	55	56
1952				64	70	65
1953				60	64	61
1954				66	71	67
1955				70	75	71
1956				75	80	76
1960		44	44	84	87	85
1965	32	47	38	89	89	89
1966	32	46	37	90	89	89
1967	33	46	38	90	91	91
1968	33	46	38	90	91	90
1969	34	46	39	90	91	90
1970	34	46	39	90	90	90
1971	36	47	41	90	90	90
1972	39	49	43	91	89	90
1973	41	52	46	92	90	91
1974	44	54	48	94	91	93
1975	46	56	50	93	93	93
1976	49	57	53	94	93	93
1977	49	57	53	95	93	94
1978	52	59	55	95	93	94
1979	51	59	54	95	93	94
1980	52	59	55	95	93	94
1981	53	59	55	95	93	94
1982	54	59	56	95	93	94
1983	57	59	58	96	89	93
1984	57	59	58	97	90	93
1985	57	59	58	96	89	92
1986	58	59	58	96	89	92
1987	59	59	59	96	89	92

[1] Includes both OASI and DI worker benefits.

Source: Social Security Bulletin, Annual Statistical Supplement, 1987, Table 42, and Office of Research and Statistics.

TABLE 6.—NUMBER OF OASDI BENEFIT RECIPIENTS WITH BENEFITS IN CURRENT-PAYMENT STATUS, BY BENEFICIARY TYPE, DECEMBER 1940–86

[In thousands]

At end of selected year	Retired workers and auxiliaries								Disabled workers and auxiliaries			
	Total	Retired workers	Wives and husbands	Children	Widowed mothers and fathers	Widows and widowers	Parents	Persons with special age–72 benefits	Total	Disabled workers	Wives and husbands	Children
1940	222	112	30	55	20	4	1	...	...	...	...	...
1945	1,288	518	159	390	121	94	6	...	...	...	...	...
1950	3,477	1,771	508	700	169	314	15	...	...	...	...	...
1955	7,961	4,474	1,192	1,276	292	701	25	...	...	...	...	...
1960	14,157	8,061	2,269	1,845	401	1,544	36	...	687	455	77	155
1961	15,468	8,925	2,392	1,989	428	1,697	37	...	1,027	618	118	291
1962	16,778	9,739	2,531	2,160	452	1,859	37	...	1,275	741	147	387
1963	17,583	10,263	2,581	2,230	462	2,011	37	...	1,452	827	168	457
1964	18,236	10,669	2,604	2,298	471	2,159	36	...	1,563	894	179	490
1965	19,128	11,101	2,614	2,535	472	2,371	35	...	1,739	988	193	558
1966	20,797	11,658	2,640	2,739	488	2,602	35	634	1,970	1,097	220	654
1967	21,565	12,019	2,645	2,873	496	2,770	33	729	2,140	1,193	235	713
1968	22,225	12,421	2,645	3,009	505	2,938	32	676	2,335	1,295	253	787
1969	22,827	12,822	2,644	3,123	512	3,092	30	603	2,488	1,394	264	829
1970	23,564	13,349	2,668	3,234	523	3,227	29	534	2,665	1,493	283	889
1971	24,362	13,927	2,698	3,336	535	3,366	27	472	2,930	1,648	312	971
1972	25,205	14,555	2,735	3,427	541	3,510	26	410	3,271	1,833	350	1,088
1973	26,310	15,365	2,808	3,526	572	3,656	25	358	3,559	2,017	381	1,161

1974	26,941	15,959	2,826	3,513	574	3,770	23	278	3,911	2,237	412	1,263
1975	27,732	16,588	2,867	3,562	582	3,889	21	223	4,352	2,489	453	1,411
1976	28,397	17,164	2,896	3,556	579	3,994	20	188	4,624	2,670	474	1,480
1977	29,217	17,821	2,961	3,552	583	4,119	18	159	4,860	2,837	495	1,525
1978	29,718	18,358	2,980	3,441	576	4,212	17	134	4,868	2,880	492	1,497
1979	30,347	18,970	2,991	3,363	574	4,321	16	112	4,777	2,871	475	1,431
1980	30,907	19,562	3,016	3,249	562	4,411	15	93	4,678	2,859	462	1,358
1981[1]	31,550	20,195	3,031	3,178	548	4,508	14	76	4,456	2,777	428	1,252
1982	31,866	20,763	3,039	2,879	515	4,595	12	63	3,973	2,604	366	1,004
1983	32,272	21,419	3,039	2,657	400	4,694	11	51	3,813	2,569	308	936
1984	32,657	21,906	3,051	2,487	382	4,779	10	40	3,822	2,597	304	921
1985	33,151	22,432	3,069	2,374	372	4,863	10	32	3,907	2,657	306	945
1986 [1]	33,715	22,987	3,088	2,325	350	4,931	9	25	3,993	2,727	301	965

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[1] Based on unedited monthly data.

Source: Social Security Bulletin, Annual Statistical Supplement, 1987, Tables 80, 106, and 108.

TABLE 7.—OASDI BENEFICIARY FAMILIES WITH BENEFITS IN CURRENT-PAY STATUS, BY SELECTED FAMILY GROUPS, SELECTED YEARS, 1944–86

[In thousands]

Year [1]	Retired-worker families				Survivor families				Disabled-worker families					
	Worker only			Worker and wife	Aged widow only	Widowed mother and—			Worker only			Worker, wife, and—		Worker and spouse
	Total	Men	Women			1 child	2 children	3 or more children	Total	Men	Women	1 child	2 or more children	
1944	315	253	62	135	69	67	36	20						
1950	1,240	939	301	498	314	82	53	33						
1955	3,266	2,054	1,212	1,124	700	126	86	80						
1960	5,742	2,922	2,820	2,122	1,527	172	113	114	357	261	96	22	32	22
1965	8,386	4,137	4,249	2,400	2,332	182	135	153	714	481	232	54	109	30
1970	10,533	4,904	5,629	2,457	3,080	183	155	182	1,054	680	374	77	164	43
1975	13,520	6,134	7,385	2,618	3,606	221	182	176	1,750	1,080	671	137	250	66
1976	14,056	6,351	7,705	2,647	3,706	219	186	171	1,883	1,152	730	144	257	72
1977	14,597	6,564	8,033	2,681	3,805	221	190	167	2,000	1,222	782	152	263	80
1978	15,148	6,791	8,357	2,697	3,894	228	186	158	2,043	1,245	798	155	256	81
1979	15,748	7,044	8,704	2,710	3,964	234	187	147	2,050	1,248	802	154	242	80
1980	16,314	7,286	9,028	2,736	4,033	239	184	134	2,061	1,257	804	154	228	80
1982	17,519	7,852	9,667	2,784	4,191	236	165	106	1,969	1,208	760	124	163	78
1983	18,162	8,166	9,996	2,830	4,271	161	141	92	1,961	1,215	746	85	143	80
1984	18,613	8,362	10,251	2,839	4,520	159	135	79	1,993	1,241	752	83	140	76
1985	19,132	8,601	10,531	2,861	4,606	158	131	74	2,039	1,267	772	84	140	76
1986	19,664	8,849	10,816	2,883	4,666	151	123	68	2,096	1,301	795	82	136	74

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[1] Data for 1981 are not available.

Source: Social Security Bulletin, Annual Statistical Supplement, 1987, Table 122.

TABLE 8.—OASDI AVERAGE MONTHLY BENEFITS IN CURRENT-PAYMENT STATUS, BY SELECTED FAMILY GROUPS, SELECTED YEARS, 1944–86

[Average monthly amount]

At end of year [1]	Retired-worker families				Survivor families				Disabled-worker families					
	Worker only			Worker and wife	Aged widow only	Widowed mother and—			Worker only			Worker, wife, and—		Worker and spouse
	Total	Men	Women			1 child	2 children	3 or more children	Total	Men	Women	1 child	2 or more children	
1944	23.00	24.10	19.30	37.90	20.20	34.40	47.30	50.10						
1950	42.20	44.60	34.80	71.70	36.50	76.90	93.90	92.40						
1955	59.10	64.60	49.80	103.50	48.70	106.80	135.40	133.20						
1960	69.90	79.90	59.60	123.90	57.70	131.70	188.00	181.70	87.90	91.90	76.90	184.70	192.20	135.50
1965	80.10	90.50	70.00	141.50	73.90	153.00	219.80	218.10	95.40	100.70	85.00	201.00	216.30	145.90
1970	114.20	128.70	101.60	198.90	102.40	213.00	291.10	289.90	128.10	136.30	113.10	264.10	273.20	199.20
1975	201.60	225.50	181.80	343.90	195.90	367.20	468.60	461.80	218.90	240.00	185.00	441.00	454.00	344.00
1976	218.80	245.10	197.10	373.10	211.00	399.80	503.40	499.70	327.40	261.40	199.40	482.20	495.70	377.00
1977	236.80	265.90	213.10	404.40	226.50	436.80	546.60	538.60	265.50	283.80	213.80	525.80	538.10	407.50
1978	256.60	288.90	230.30	437.50	243.60	474.00	591.90	582.80	277.90	308.50	230.20	568.00	585.90	443.00
1979	287.00	324.00	257.10	488.60	270.30	532.90	655.00	646.70	308.90	343.60	254.80	632.70	655.70	497.10
1980	333.00	377.10	297.40	566.60	311.60	612.80	759.20	740.50	355.40	396.20	291.70	727.00	746.10	573.00
1982	408.90	465.50	362.90	702.50	379.00	735.60	885.50	867.90	424.20	474.20	344.70	847.40	858.20	690.70
1983	429.70	490.00	380.40	742.90	400.60	774.80	923.00	884.50	439.40	490.40	355.40	867.90	881.80	716.20
1984	448.20	511.60	396.40	781.20	416.30	805.30	948.30	906.60	454.00	507.60	365.70	881.50	885.50	740.40
1985	465.80	531.80	412.00	813.90	434.30	829.60	981.50	924.90	466.90	523.10	374.60	898.10	895.20	765.00
1986	475.20	542.60	420.10	831.30	444.90	841.70	994.00	939.80	470.70	527.80	377.40	896.90	888.30	773.30

[1] Data for 1981 not available.

Source: Social Security Bulletin, Annual Statistical Supplement, 1987, Table 122, and Office of Research and Statistics.

TABLE 9.—HISTORICAL COMPARISON OF AVERAGE WAGE INCREASES TO BENEFIT INCREASES AND CHANGES IN CPI, 1965–87

[In percent]

	Increases in wages [1]		Increase in CPI [2]		Increase in benefits [3]	
	Over prior year	Cumulative from each year to 1986	Over prior year	Cumulative from each year to 1986	Over prior year	Cumulative from each year to 1986
1965	1.8	283.6	1.7	253.9	7.0	331.6
1966	6.0	261.9	2.9	243.9	0.0	331.6
1967	5.6	242.7	2.9	234.2	0.0	331.6
1968	6.9	220.6	4.2	220.7	13.0	281.9
1969	5.8	203.0	5.4	204.3	0.0	281.9
1970	5.0	188.6	5.9	187.3	15.0	232.1
1971	5.0	174.8	4.3	175.5	10.0	201.9
1972	9.8	150.3	3.3	166.7	20.0	151.6
1973	6.3	135.5	6.2	151.1	0.0	151.6
1974	5.9	122.4	11.0	126.2	11.0	126.7
1975	7.5	106.8	9.1	107.4	8.0	109.9
1976	6.9	93.5	5.7	96.2	6.4	97.2
1977	6.0	82.5	6.5	84.2	5.9	86.3
1978	7.9	69.2	7.6	71.2	6.5	74.9
1979	8.7	55.6	11.4	53.7	9.9	59.1
1980	9.0	42.8	13.5	35.4	14.3	39.2
1981	10.1	29.7	10.2	22.9	11.2	25.2
1982	5.5	22.9	6.0	15.9	7.4	16.6
1983	4.9	17.2	3.0	12.5	[4] 3.5	12.6
1984	5.9	10.7	3.4	8.8	3.5	8.8
1985	4.3	6.1	3.5	5.2	3.1	5.6
1986	3.0	3.0	1.5	3.6	1.3	4.2
1987	[5] 3.0	....	3.6	....	[6] 4.2	....

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[1] Average annual earnings series used to index earnings records.

[2] Increase in annual average CPI–W.

[3] Legislated benefit increases through 1975 and increases based on CPI thereafter.

[4] As a result of the Social Security Amendments of 1983, COLA's are provided on a calendar year basis, with the benefit increase payable in January rather than July. The July 1983 COLA was delayed to January 1984. This delay and a change in the computation period led to 6 months of 1983 not being accounted for in any COLA increase.

[5] Preliminary.

[6] Effective December 1987, payable January 1988.

Source: Office of Research and Statistics, Social Security Administration.

TABLE 10.—OASDHI EXPENDITURES AS PERCENT OF TOTAL SOCIAL WELFARE EXPENDITURE [1]

[Dollars in millions]

	Total expenditure [2]	OASDHI	Percent
1929	$3,921		
1940	8,795	$40.4	0.5
1950	23,508	784.1	3.3
1955	32,640	4,436.3	13.6
1960	52,293	11,032.3	21.1
1965	77,175	16,997.5	22.0
1970	145,856	36,835.4	25.3
1975	290,080	78,429.9	27.0
1979	430,280	131,719.4	30.6
1980	492,528	152,110.4	30.9
1981	550,324	180,425.0	32.8
1982	594,785	204,567.8	34.4
1983	641,169	224,709.2	35.0
1984	670,945	239,395.0	35.7
1985	727,861	260,468.7	35.8

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[1] Expenditures include those from Federal, State and local revenues (general and special) and trust funds and other expenditures under public law.

[2] Includes expenditures for public education, health and medical programs, veteran's programs, public aid (including SSI and food stamps) as well as social insurance programs other than social security.

Source: Social Security Bulletin, Annual Statistical Supplement, 1987, Table 3.

TABLE 11.—TOTAL OASDI BENEFITS PAID, AND AS A PERCENT OF PERSONAL INCOME

[In millions]

Year	Total cash benefits	Cash benefits		Personal income [1]	Total (cash) benefits as a percent of personal income
		OASI	DI		
1937	$1	$1	...	$73,400	(2)
1938	10	10	...	67,600	(2)
1939	14	14	...	72,100	(2)
1940	35	35	...	77,600	(2)
1941	88	88	...	95,200	0.1
1942	131	131	...	122,400	.1
1943	166	166	...	150,700	.1
1944	209	207	...	164,500	.1
1945	274	274	...	170,000	.2
1946	378	378	...	177,600	.2
1947	466	466	...	190,200	.2
1948	556	556	...	209,200	.3
1949	667	667	...	206,400	.3
1950	961	961	...	228,100	.4
1951	1,885	1,885	...	256,500	.7
1952	2,194	2,194	...	273,800	.8
1953	3,006	3,006	...	290,500	1.0
1954	3,670	3,670	...	293,000	1.3
1955	4,968	4,968	...	314,200	1.6
1956	5,715	5,715	...	337,200	1.7
1957	7,404	7,347	$57	356,300	2.1
1958	8,576	8,327	249	367,100	2.3
1959	10,298	9,846	457	390,700	2.6
1960	11,245	10,677	568	409,400	2.7
1961	12,749	11,862	887	426,000	3.0
1962	14,461	13,356	1,105	453,200	3.2
1963	15,427	14,217	1,210	476,300	3.2
1964	16,223	14,914	1,309	510,200	3.2
1965	18,311	16,737	1,573	552,000	3.3
1966	20,048	18,267	1,781	600,800	3.3
1967	21,407	19,468	1,939	644,500	3.3
1968	24,936	22,642	2,294	707,200	3.5
1969	26,751	24,209	2,542	772,900	3.5
1970	31,863	28,796	3,067	831,800	3.8
1971	37,171	33,413	3,758	894,000	4.2
1972	41,595	37,122	4,473	981,600	4.2
1973	51,459	45,741	5,718	1,101,700	4.7
1974	58,521	51,618	6,903	1,210,100	4.8
1975	66,923	58,509	8,414	1,313,400	5.1
1976	75,665	65,699	9,966	1,451,400	5.2

TABLE 11.—TOTAL OASDI BENEFITS PAID, AND AS A PERCENT OF PERSONAL INCOME—Continued

[In millions]

Year	Total cash benefits	Cash benefits		Personal income [1]	Total (cash) benefits as a percent of personal income
		OASI	DI		
1977	84,576	73,113	11,463	1,607,500	5.3
1978	92,865	80,352	12,513	1,812,400	5.1
1979	104,264	90,556	13,708	2,034,000	5.1
1980	120,511	105,074	15,437	2,258,500	5.3
1981	140,994	123,795	17,199	2,520,900	5.6
1982	156,138	138,800	17,338	2,670,800	5.8
1983	167,032	149,502	17,530	2,836,400	5.9
1984	175,762	157,862	17,900	3,111,900	5.6
1985	186,196	167,360	18,836	[3] 3,314,500	5.6
1986	196,692	176,845	19,847	[3] 3,485,700	7.8
1987	[4] 204,505	[4] 184,059	[4] 20,446	[3] 3,633,700	7.8

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[1] Data from "Survey of Current Business". Revised historical data (1937–84) February 1986 Table 6; 1985 data from October 1986, table 2.1.

[2] Less than 0.05 percent.

[3] Rounded to nearest 100 million.

[4] Projected.

Source: Social Security Bulletin Annual Statistical Supplement, 1987, Table 26.

TABLE 12.—ESTIMATED COST OF OASDI AND HI SYSTEMS AS PERCENT OF GNP UNDER ALTERNATIVE II–B, 1987–2060

[In percent]

Calendar year	OASDI	HI	OASDI and HI
Alternative II–B:			
1987	4.73	1.16	5.89
1990	4.71	1.27	5.98
1995	4.68	1.44	6.11
2000	4.43	1.55	5.98
2005	4.25	1.66	5.90
2010	4.44	1.78	6.22
2015	4.94	1.95	6.90
2020	5.60	2.19	7.79
2025	6.17	2.48	8.65
2030	6.47	2.72	9.19
2035	6.51	2.86	9.36
2040	6.38	2.90	9.28
2045	6.26	2.90	9.17
2050	6.22	2.88	9.10
2055	6.18	2.86	9.04
2060	6.12	2.84	8.96
25-year averages:			
1987–2011	4.51	1.51	6.02
2012–2036	5.86	2.40	8.26
2037–2061	6.25	2.88	9.13
75-year average:			
1987–2061	5.54	2.26	7.80

Source: 1987 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, Table F1.

TABLE 13.—COST RATES FOR THE OASI AND DI TRUST FUNDS AS A PERCENT OF TAXABLE PAYROLL, 1940–86

[In percent]

Calendar year	OAI [1]	SI [1]	OASI	DI	OASDI
1940	0.10	0.09	0.19	....	0.19
1941	.16	.11	.27	....	.27
1942	.17	.13	.30	....	.30
1943	.18	.14	.32	....	.32
1944	.20	.16	.36	....	.36
1945	.26	.22	.48	....	.48
1946	.36	.25	.61	....	.61
1947	.40	.25	.65	....	.65
1948	.46	.26	.72	....	.72
1949	.58	.31	.89	....	.89
1950	.79	.38	1.17	....	1.17

TABLE 13.—COST RATES FOR THE OASI AND DI TRUST FUNDS AS A PERCENT OF TAXABLE PAYROLL, 1940–86—Continued

[In percent]

Calendar year	OAI [1]	SI [1]	OASI	DI	OASDI
1951	1.18	.50	1.68	....	1.68
1952	1.28	.55	1.83	....	1.83
1953	1.71	.64	2.35	....	2.35
1954	2.12	.77	2.89	....	2.89
1955	2.52	.82	3.34	....	3.34
1956	2.72	.84	3.56	....	3.56
1957	3.32	.97	4.29	.03	4.32
1958	3.85	1.10	4.95	.15	5.10
1959	4.07	1.20	5.27	.24	5.51
1960	4.29	1.30	5.59	.30	5.89
1961	4.67	1.46	6.13	.47	6.60
1962	5.02	1.58	6.60	.56	7.16
1963	5.19	1.65	6.84	.59	7.43
1964	5.17	1.66	6.83	.62	7.45
1965	5.42	1.81	7.23	.70	7.93
1966	4.58	1.66	6.24	.64	6.88
1967	4.63	1.64	6.27	.65	6.92
1968	4.64	1.71	6.35	.67	7.03
1969	4.66	1.72	6.38	.70	7.08
1970	5.36	1.96	7.32	.81	8.12
1971	6.07	2.20	8.27	.97	9.23
1972	5.98	2.15	8.13	1.01	9.14
1973	6.21	2.38	8.59	1.09	9.69
1974	6.20	2.35	8.55	1.16	9.70
1975	6.77	2.52	9.29	1.36	10.65
1976	6.89	2.53	9.42	1.44	10.86
1977	6.93	2.53	9.46	1.50	10.97
1978	6.85	2.44	9.29	1.45	10.74
1979	6.57	2.31	8.88	1.35	10.23
1980	6.95	2.41	9.36	1.38	10.74
1981	7.45	2.52	9.97	1.39	11.36
1982 [2]	8.01	2.58	10.59	1.34	11.94
1983 [2]	7.84	2.43	10.27	1.22	11.50
1984 [2]	7.73	2.35	10.08	1.16	11.24
1985 [2]	7.67	2.32	9.99	1.14	11.13
1986 [3]	7.62	2.29	9.91	1.12	11.03

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[1] These estimates are based on the assumption that total OASI expenditures are distributed between OAI and SI in the same proportions as benefit payments.

[2] Preliminary.

[3] Estimates based on the Alternative II–B assumptions of the 1987 Trustees Report.

Note: All numbers in this table are presented as percentages of taxable payroll and are based on data published in 1987 and earlier Trustees Reports.

Source: Office of the Actuary, Social Security Administration.

TABLE 14.—ESTIMATED COST RATES FOR THE OASDI TRUST FUND AS A PERCENT OF TAXABLE PAYROLL, 1987–2065

[In percent]

Calendar year	OAI	SI	OASI	DI	OASDI
1987	7.58	2.21	9.79	1.10	10.89
1990	7.69	2.23	9.92	1.06	10.98
1995	7.63	2.19	9.82	1.06	10.87
2000	7.20	1.95	9.15	1.16	10.31
2005	6.85	1.74	8.59	1.35	9.94
2010	7.22	1.65	8.87	1.58	10.46
2015	8.37	1.65	10.02	1.72	11.75
2020	9.90	1.72	11.62	1.81	13.43
2025	11.23	1.80	13.03	1.90	14.93
2030	12.10	1.87	13.97	1.87	15.83
2035	12.34	1.92	14.26	1.81	16.06
2040	12.15	1.95	14.10	1.80	15.90
2045	11.95	1.96	13.91	1.85	15.77
2050	11.98	1.95	13.93	1.87	15.80
2055	12.08	1.93	14.01	1.86	15.87
2060	12.11	1.91	14.02	1.84	15.85
2065	12.12	1.90	14.02	1.84	15.86
25-year averages:					
1987–2011	7.32	1.97	9.29	1.22	10.51
2012–2036	10.59	1.78	12.37	1.81	14.18
2037–2061	12.06	1.94	14.00	1.84	15.85
75-year average:					
1987–2061	9.99	1.90	11.89	1.63	13.51

Note: All estimates in this table are presented as percentages of taxable payroll and are based on the Alternative II–B assumptions of the 1987 Trustees Report.

Source: Office of the Actuary, Social Security Administration.

TABLE 15.—PAST AND FUTURE EARNINGS LEVELS, PRIMARY INSURANCE AMOUNTS IN ACTUAL AND CONSTANT DOLLARS, AND REPLACEMENT RATES, UNDER PRESENT LAW, 1953–2040 [1]

Calendar year	Actual earnings in previous year			Sum of monthly PIA's in year of entitlement [2]						Replacement rates [3] (in percent)		
				Actual dollars			1987 constant dollars					
	Low earner	Average earner	Maximum earner [4]	Low earner	Average earner	Maximum earner [4]	Low earner	Average earner	Maximum earner [4]	Low earner	Average earner	Maximum earner [4]
1953 [5]	1,560	2,973	3,600	714	912	1,020	2,969	3,792	4,241	45.8	30.7	28.3
1955 [5]	1,560	3,156	3,600	774	1,091	1,182	3,214	4,530	4,909	49.6	34.6	32.8
1960 [5]	2,080	3,856	4,800	936	1,284	1,428	3,519	4,827	5,369	45.0	33.3	29.8
1965 [5]	2,600	4,576	4,800	1,040	1,439	1,580	3,672	5,077	5,577	40.0	31.4	32.9
1970 [5]	3,328	5,894	7,800	1,421	2,021	2,278	4,074	5,795	6,531	42.7	34.3	29.2
1975 [5]	3,883	8,031	13,200	2,309	3,400	3,973	4,777	7,034	8,220	59.5	42.3	30.1
1980 [5]	6,032	11,479	22,900	3,859	5,862	7,437	5,210	7,915	10,041	64.0	51.1	32.5
1985	6,968	16,135	37,800	[6] 4,445	6,598	8,629	6,655	4,908	9,035	[6] 63.8	40.9	22.8
1988	7,352	18,036	43,800	4,975	7,542	10,101	4,750	7,220	9,669	71.2	41.8	23.1
1990	7,678	19,874	46,800	5,698	8,674	11,751	5,002	7,615	10,316	74.2	43.6	25.1
2000	13,096	33,897	79,800	8,966	14,003	20,208	5,304	8,283	11,954	68.5	41.3	25.3
2010	22,370	57,900	135,900	14,502	23,910	36,794	5,795	9,555	14,704	64.8	41.3	27.2
2020	38,211	98,902	231,900	23,692	40,846	64,283	6,396	11,027	17,355	62.0	41.3	27.7
2030	65,269	168,939	396,600	39,078	69,779	109,819	7,127	12,727	20,029	59.9	41.3	27.7
2040	111,489	288,573	677,700	66,715	119,197	187,355	8,220	14,686	23,084	59.8	41.3	27.6

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[1] For workers becoming entitled for January at age 65 with steady career earnings. [2] Sum rounded to nearest dollars.

[3] Sum of monthly PIA's in year of entitlement expressed as percent of earnings in year prior to entitlement. [4] Earnings equal to the social security taxable earnings base.

[5] PIA's and replacement rates for these workers are based on the pre-1977 benefit formula. [6] Based on special minimum PIA computation.

Source: Office of the Actuary, Social Security Administration.

Note: For those illustrative cases retiring at age 65 in 2010 and later, the "normal retirement age" is greater than 65 and, therefore, an actuarial-reduction factor will apply. Thus, showing the PIA's for such persons is somewhat inappropriate.

TABLE 16.—COMPARISON OF REPLACEMENT RATES FOR SINGLE WORKERS RETIRING AT NORMAL RETIREMENT AGE UNDER PRIOR SOCIAL SECURITY ACTS AND PRESENT LAW [1]

[In percent]

Act	Earnings level [2]		
	Low	Average	Maximum
1935: [3]			
Minimum coverage	30.0	20.0	10.0
Maximum coverage	73.0	58.0	34.0
1939: [3]			
Minimum coverage	41.2	28.8	16.5
Maximum coverage	57.2	40.0	22.9
1950	44.7	30.0	26.7
1952	45.2	30.3	28.3
1954	47.6	34.0	31.0
1958	46.7	34.2	31.8
1965	44.2	33.5	30.5
1967	46.9	36.3	33.5
1969	51.7	40.3	38.6
1971	53.5	43.0	39.4
1972	62.7	51.2	42.7
1975	70.2	55.9	42.6
1977 [4]	52.4	40.8	27.4
1983 (Present law)	58.7	40.7	27.1

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[1] Replacement rate is defined as the ratio of the annual rate of benefit payment as of the date of retirement at the beginning of the year to the annual earnings in the previous year. Normal retirement age is 65, except under 1983 law when it was increased to 67.

[2] The annual average earnings level is assumed to be $1,000 for the computations under the 1935 and 1939 Acts (because wages were relatively stable in the late 1930's), and equal to average earnings in the economy for subsequent computations. The low earnings level is approximately 50 percent of the average level, and the maximum is equal to the applicable maximum taxable wage base.

[3] The minimum coverage was 5 years for the 1935 Act and 3 years for the 1939 Act; the length of coverage for steady worker generally has no effect on benefits under subsequent Acts. The maximum coverage was taken as 43 years (from age 22 to age 65) for both the 1935 and 1939 Acts (actually, 43 years was the maximum creditable under the maximum-earnings case under the 1935 Act).

[4] Ultimate replacement rates shown taken from Table 3.5 in "Social Security" by Robert J. Myers.

FINANCING

The payroll tax is imposed on covered earnings up to a specific dollar amount. Workers who earn more than the maximum taxable earnings base do not pay FICA (Federal Insurance Contributions Act) or SECA (Self-Employed Contributions Act) tax on their earnings above the base.

The earnings base has increased numerous times from 1937 through 1988. A majority of these increases have been provided through specific legislative amendments. However, the earnings base is currently automatically adjusted annually according to the increase in average wages in the economy, but only if a cost-of-living benefit increase becomes effective for the previous December.

The tax rates have also been changed many times since 1937. Under the original act, the OASI tax rate was scheduled to gradually increase from 1 percent in 1937 to 3 percent in 1949. These increases were delayed several times during the 1940's and the tax rate did not increase to 1.5 percent until 1950. The current 1988 OASI tax rate is 5.53 percent. The tax for the disability insurance program was 0.25 percent in 1957 and is 0.53 percent in 1988. The hospital insurance (Medicare part A) rate was 0.35 percent in 1966 and is currently 1.45 percent. (For 1984 only, employees were allowed a credit of 0.3 percent of their taxable wages against their FICA tax liability, reducing the effective tax rate to 6.7 percent.)

Beginning in 1984, the OASDHI rates for self-employed persons is equal to the combined employer-employee OASDHI rate. For 1984, self-employed persons were allowed a credit (comparable to the credit allowed employers against the FICA tax) against SECA tax equal to 2.7 percent of net self-employment income. For 1985, the amount of the credit was 2.3 percent. For 1986 through 1989, the credit is 2.0 percent. The SECA tax credit may directly be taken into account in computing SECA liability for a taxable year and estimated tax payments for that year.

Effective in 1990 and thereafter, the credit would be replaced with a system designed to achieve parity between employees and the self-employed. Under this system:

1. The base of the self-employment tax will be adjusted downward to reflect the fact that employees do not pay FICA tax on the value of the employer's FICA tax.
2. A deduction will be allowed for income tax purposes, for half of SECA liability, to allow for the fact that employees do not pay income tax on the value of the employer's FICA tax.

The following four tables detail the annual taxable earnings base, the three individual and combined tax rates and the annual maximum contribution for both employees, employers, and self-employed persons:

TABLE 17.—ANNUAL MAXIMUM TAXABLE EARNINGS AND CONTRIBUTION RATE: EMPLOYERS AND EMPLOYEES, 1937–2000 AND THEREAFTER

Beginning—	Annual maximum taxable earnings	Contribution rate			
		Total	OASI	DI	HI
1937	$3,000	1	1		
1950	3,000	1.5	1.5		
1951	3,600	1.5	1.5		
1954	3,600	2	2		
1955	4,200	2	2		
1957	4,200	2.25	2	0.25	
1959	4,800	2.5	2.25	.25	
1960	4,800	3	2.75	.25	
1962	4,800	3.125	2.875	.25	
1963	4,800	3.625	3.375	.25	
1966	6,600	4.2	3.5	.35	0.35
1967	6,600	4.4	3.55	.35	.5
1968	7,800	4.4	3.325	.475	.6
1969	7,800	4.8	3.725	.475	.6
1970	7,800	4.8	3.65	.55	.6
1971	7,800	5.2	4.05	.55	.6
1972	9,000	5.2	4.05	.55	.6
1973	10,800	5.85	4.3	.55	1.0
1974	13,200	5.85	4.375	.575	.9
1975	14,100	5.85	4.375	.575	.9
1976	15,300	5.85	4.375	.575	.9
1977	16,500	5.85	4.375	.575	.9
1978	17,700	6.05	4.275	.775	1.00
1979	22,900	6.13	4.33	.75	1.05
1980	25,900	6.13	4.52	.56	1.05
1981	29,700	6.65	4.70	.65	1.3
1982	32,400	6.7	4.575	.825	1.3
1983	35,700	6.7	4.775	.625	1.3
1984 [1]	37,800	7.0	5.2	.5	1.3
1985	39,600	7.05	5.2	.5	1.35
1986	42,000	7.15	5.2	.5	1.45
1987	43,800	7.15	5.2	.5	1.45
1988	45,000	7.51	5.53	.53	1.45
1989	(2)	7.51	5.53	.53	1.45
1990–1999	(2)	7.65	5.6	.60	1.45
2000 and thereafter	(2)	7.65	5.49	.71	1.45

[1] Tax credits apply for 1984.

[2] Subject to automatic increase.

Source: Social Security Bulletin, Annual Statistical Supplement, 1987, Table D.

TABLE 18.—MAXIMUM ANNUAL CONTRIBUTION: EMPLOYEE, 1937–88

Beginning—	Total	OASI	DI	HI
1937	$30.00	$30.00		
1950	45.00	45.00		
1951	54.00	54.00		
1954	72.00	72.00		
1955	84.00	84.00		
1957	94.50	84.00	$10.50	
1959	120.00	108.00	12.00	
1960	144.00	132.00	12.00	
1962	150.00	138.00	12.00	
1963	174.00	162.00	12.00	
1966	277.20	231.00	23.10	$23.10
1967	290.40	234.30	23.10	33.00
1968	343.20	259.35	37.05	46.80
1969	374.40	290.55	37.05	46.80
1970	374.40	284.70	42.90	46.80
1971	405.60	315.90	42.90	46.80
1972	468.00	364.50	49.50	54.00
1973	631.80	464.40	59.40	108.00
1974	772.20	577.50	75.90	118.80
1975	824.85	618.88	81.08	126.90
1976	895.05	669.38	87.98	137.70
1977	965.25	721.88	94.88	148.50
1978	1,070.85	756.68	137.18	177.00
1979	1,403.77	991.57	171.75	240.45
1980	1,587.67	1,170.68	145.04	271.95
1981	1,975.05	1,395.90	193.05	386.10
1982	2,170.80	1,482.30	267.30	421.20
1983	2,391.90	1,704.68	223.12	464.10
1984 [1]	2,646.00	1,965.60	189.00	491.40
1985	2,791.80	2,059.20	198.00	534.60
1986	3,003.00	2,184.00	210.00	609.00
1987	3,131.70	2,277.60	219.00	635.10
1988	3,379.50	2,488.50	238.50	652.50
Total cumulative employee contributions 1954 to 1988 [1]	33,683.38	24,911.02	2,951.76	5,820.60

[1] Includes tax credit.

Source: Social Security Bulletin, Annual Statistical Supplement, 1987, Table F.

TABLE 19—ANNUAL MAXIMUM TAXABLE EARNINGS AND CONTRIBUTION RATE: SELF-EMPLOYED, 1937–2000 AND THEREAFTER

Beginning—	Annual maximum taxable earnings	Contribution rate			
		Total	OASI	DI	HI
1937	$3,000	...	...	...	...
1950	3,000	...	...	...	...
1951	3,600	2.25	2.25	...	...
1954	3,600	3	3	...	...
1955	4,200	3	3	...	...
1957	4,200	3.375	3	0.375	...
1959	4,800	3.75	3.375	.375	...
1960	4,800	4.5	4.125	.375	...
1962	4,800	4.7	4.325	.375	...
1963	4,800	5.4	5.025	.375	...
1966	6,600	6.15	5.275	.525	0.35
1967	6,600	6.4	5.375	.525	.5
1968	7,800	6.4	5.0875	.7125	.6
1969	7,800	6.9	5.5875	.7125	.6
1970	7,800	6.9	5.475	.825	.6
1971	7,800	7.5	6.075	.825	.6
1972	9,000	7.5	6.075	.825	.6
1973	10,800	8	6.205	.795	1.0
1974	13,200	7.9	6.185	.815	.9
1975	14,100	7.9	6.185	.815	.9
1976	15,300	7.9	6.185	.815	.9
1977	16,500	7.9	6.185	.815	.9
1978	17,700	8.10	6.01	1.09	1.00
1979	22,900	8.10	6.01	1.04	1.05
1980	25,900	8.10	6.2725	.7775	1.05
1981	29,700	9.30	7.025	.975	1.30
1982	32,400	9.35	6.8125	1.2375	1.30
1983	35,700	9.35	7.1125	.9375	1.30
1984 [1]	37,800	14.0	10.4	1.0	2.6
1985 [1]	39,600	14.1	10.4	1.0	2.7
1986 [1]	42,000	14.3	10.4	1.0	2.9
1987 [1]	43,800	14.3	10.4	1.0	2.9
1988 [1]	45,000	15.02	11.06	1.06	2.9
1989 [1]	([2])	15.02	11.06	1.06	2.9
1990–1999	([2])	15.3	11.2	1.2	2.9
2000 and thereafter	([2])	15.3	10.98	1.42	2.9

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[1] Tax credits apply from 1984 through 1989.

[2] Subject to automatic increase.

Source: Social Security Bulletin, Annual Statistical Supplement, 1987, Table D.

TABLE 20.—MAXIMUM ANNUAL CONTRIBUTION: SELF-EMPLOYED, 1937–88

Beginning—	Total	OASI	DI	HI
1937				
1950				
1951	$81.00	$81.00		
1954	108.00	108.00		
1955	126.00	126.00		
1957	141.75	126.00	$15.75	
1959	180.00	162.00	18.00	
1960	216.00	198.00	18.00	
1962	225.60	207.60	18.00	
1963	259.20	241.20	18.00	
1966	405.90	348.15	34.65	$23.10
1967	422.40	354.75	34.65	33.00
1968	499.20	396.82	55.57	46.80
1969	538.20	435.82	55.57	46.80
1970	538.20	427.05	64.35	46.80
1971	585.00	473.85	64.35	46.80
1972	675.00	546.75	74.25	54.00
1973	864.00	670.14	85.86	108.00
1974	1,042.80	816.42	107.58	118.80
1975	1,113.90	872.08	114.91	126.90
1976	1,208.70	946.30	124.69	137.70
1977	1,303.50	1,020.52	134.47	148.50
1978	1,433.70	1,063.77	192.93	177.00
1979	1,854.90	1,376.29	238.16	240.45
1980	2,097.90	1,624.58	201.37	271.95
1981	2,762.10	2,086.43	289.57	386.10
1982	3,029.40	2,207.25	400.95	421.20
1983	3,337.95	2,539.16	334.69	464.10
1984 [1]	5,292.00	3,931.20	378.00	982.80
1985 [1]	5,583.60	4,118.40	396.00	1,069.20
1986 [1]	6,006.00	4,368.00	420.00	1,218.00
1987 [1]	6,263.40	4,555.20	438.00	1,270.20
1988 [1]	6,759.00	4,977.00	477.00	1,305.00
Cumulative contributions, 1954 to 1988 [1]	55,875.45	42,257.16	4,875.09	8,743.20

[1] Includes tax credit.

Source: Social Security Bulletin, Annual Statistical Supplement, 1987, Table F.

Table 21 indicates the status of the three major social security funds, both separated and combined, measured as assets available at the beginning of each year as a percent of actual outgo during the year.

TABLE 21.—ASSETS OF OLD-AGE AND SURVIVORS INSURANCE (OASI), DISABILITY INSURANCE (DI), AND HOSPITAL INSURANCE TRUST FUNDS AT BEGINNING OF YEAR AS PERCENT OF OUTGO DURING YEAR

[In percent]

Calendar year	OASI	DI	HI	Combined
1937				
1938	7,660			7,660
1939	8,085			8,085
1940	2,781			2,781
1941	1,782			1,782
1942	1,737			1,737
1943	1,891			1,891
1944	2,025			2,025
1945	1,975			1,975
1946	1,704			1,704
1947	1,592			1,592
1948	1,542			1,542
1949	1,487			1,487
1950	1,156			1,156
1951	698			698
1952	681			681
1953	564			564
1954	500			500
1955	405			405
1956	371			371
1957	300			300
1958	259	249		259
1959	212	284		215
1960	180	304		186
1961	164	239		169
1962	141	206		146
1963	123	183		128
1964	118	159		122
1965	109	121		110
1966	96	83		91
1967	101	83	28	90
1968	103	83	25	90
1969	102	111	43	95

TABLE 21.—ASSETS OF OLD-AGE AND SURVIVORS INSURANCE (OASI), DISABILITY INSURANCE (DI), AND HOSPITAL INSURANCE TRUST FUNDS AT BEGINNING OF YEAR AS PERCENT OF OUTGO DURING YEAR—Continued

[In percent]

Calendar year	OASI	DI	HI	Combined
1970	101	126	47	96
1971	94	140	54	93
1972	88	140	47	87
1973	75	125	40	76
1974	68	110	69	73
1975	63	92	79	68
1976	54	71	77	60
1977	47	48	66	50
1978	39	26	57	41
1979	30	30	54	34
1980	23	35	52	29
1981	18	21	45	23
1982	15	17	52	22
1983	15	14	21	16
1984	20	35	29	23
1985	24	27	32	26
1986	28	38	41	31
1987 [1]	30	44	80	41

[1] Preliminary.

Note: Assets for 1983–1986 reflect interfund borrowing. Beginning in 1984, assets of the OASI and DI Trust Funds include advance tax transfers for January.

Source: Social Security Statistical Supplement, 1983 and various trustees' reports.

Section 4. Medicare

Medicare, authorized under title XVIII of the Social Security Act, is a nationwide health insurance program for the aged and certain disabled persons. It consists of two parts: the hospital insurance (part A) program and the supplementary medical insurance (part B) program.

ELIGIBILITY

Most Americans age 65 or older are automatically entitled to protection under part A. Persons age 65 or older who are not "fully insured" (i.e., not eligible for monthly Social Security or railroad retirement cash benefits) may obtain coverage, providing they pay the full actuarial cost of such coverage. The monthly premium, as of January 1, 1988, is $234. Also eligible, after a 2-year waiting period, are people under age 65 who are receiving monthly Social Security benefits on the basis of disability and disabled railroad retirement system annuitants. (Dependents of the disabled are not eligible.) Most people who need a kidney transplant or renal dialysis because of chronic kidney disease are, under certain circumstances, entitled to benefits under part A regardless of age.

Part B of Medicare is voluntary. All persons age 65 or older (whether "insured" or not) may elect to enroll in the supplementary medical insurance program by paying the monthly premium. Persons eligible for part A by virtue of disability or chronic kidney disease may also elect to enroll in part B. The premium, as of January 1, 1988, is $24.80.

NUMBER OF BENEFICIARIES

In fiscal year 1988, approximately 28.8 million aged and 3.0 million disabled will have protection under part A. Of those, it is estimated that 6.5 million aged and 0.8 million disabled will actually receive reimbursed services. In fiscal year 1988, 28.8 million aged and 2.8 million disabled will be enrolled in part B. Over 22.8 million of the aged and 2.1 million of the disabled will receive part B reimbursed services.

TABLE 1.—NUMBER OF AGED AND DISABLED ELIGIBLE ENROLLEES AND BENEFICIARIES AND AVERAGE AND TOTAL MEDICARE BENEFIT PAYMENTS

[Persons in thousands]

	1980 (actual)	1985 (actual)	1986 (actual)	1987 (estimate)	1988 [1] (estimate)	1989 [1] (estimate)	1990 [1] (estimate)	Projected average annual growth 1985–90 (percent)
Part A:								
Persons with hospital insurance protection (monthly average):								
Aged	24,572	27,203	27,831	28,222	28,783	29,341	29,883	1.9
Disabled	2,959	2,906	2,941	2,994	3,037	3,087	3,133	1.5
Beneficiaries receiving reimbursed services:								
Aged	5,943	6,430	7,200	6,390	6,530	6,720	6,930	1.5
Disabled	737	745	800	750	765	780	805	1.6
Average annual benefit per person enrolled: [2]								
Aged	$853	$1,560	$1,541	$1,571	$1,592	$1,658	$1,814	3.1
Disabled	$951	$1,861	$1,839	$1,831	$1,857	$1,929	$2,102	2.5
Part B:								
Beneficiaries:								
Persons enrolled (average):								
Aged	24,410	27,110	27,981	28,171	28,784	29,342	29,889	2.0
Disabled	2,703	2,671	2,662	2,763	2,792	2,841	2,884	1.5
Beneficiaries receiving reimbursed services:								
Aged	15,525	19,350	21,119	22,156	22,768	23,210	23,642	4.1
Disabled	1,737	1,877	1,894	2,034	2,059	2,095	2,128	2.5
Average annual benefit per person enrolled: [2]								
Aged	$349	$686	$803	$935	$1,058	$1,183	$1,322	14.0
Disabled	$604	$1,094	$984	$1,298	$1,312	$1,415	$1,542	7.1

[1] Represents current law. Includes regulations but not the legislative proposals.
[2] Does not include administrative cost.

Source: Health Care Financing Administration.

COVERAGE

Most individuals establish entitlement to part A on the basis of work in employment covered by either the Social Security or railroad retirement systems. Certain employment is excluded from Social Security (including part A hospital insurance) taxation.

The Tax Equity and Fiscal Responsibility Act of 1982 extended the hospital insurance tax to Federal employment effective with respect to wages paid on or after January 1, 1983. Beginning January 1, 1983, Federal employment is used to determine eligibility for protection under Medicare part A. A transitional provision allows individuals who are in the employ of the Federal Government both before and during January 1, 1983, to have their prior Federal employment considered as employment for purposes of providing Medicare coverage. Newly hired employees of State and local governments hired after March 31, 1986, are liable for the HI tax.

BENEFITS

Part A of Medicare will pay for:

1. *Inpatient hospital care.*—All reasonable expenses for the first 60 days minus a deductible ($540 in calendar year 1988) in each benefit period. For days 61–90, a coinsurance amount ($135 in calendar year 1988) is deducted. When more than 90 days are required in a benefit period, a patient may elect to draw upon a 60 day lifetime reserve. A coinsurance amount ($270 in calendar year 1988) is also deducted for each reserve day.

2. *Skilled nursing facility care.*—Up to 100 days (following hospitalization) in a skilled nursing facility for persons in need of continued skilled nursing care and/or skilled rehabilitation services on a daily basis. After the first 20 days, there is a daily coinsurance amount deducted ($68.00 in calendar year 1988).

3. *Home health care.*—An unlimited number of medically necessary home health visits by nurses, therapists, and other health workers for a homebound individual.

4. *Hospice care.*—Hospice care services provided to terminally ill Medicare beneficiaries with a life expectancy of 6 months or less.

Part B of Medicare pays 80 percent of the reasonable charges (or of reasonable cost) for covered services in excess of an annual deductible ($75). Services covered include the following:

1. *Doctor's services.*—Including surgery, consultation, and home, office and institutional visits. Certain limitations apply for services rendered by dentists, podiatrists and chiropractors and for the treatment of mental illness.

2. *Other medical and health services.*—Laboratory and other diagnostic tests, X-ray and other radiation therapy, outpatient services at a hospital, rural health clinic services, home dialysis supplies and equipment, artificial devices (other than dental), physical and speech therapy, and ambulance services.

3. *Home health services.*—Unlimited number of medically necessary home health visits for persons not covered under part A. The 20 percent coinsurance and $75 deductible do not apply for such benefits.

Table 4 illustrates the deductible, coinsurance and premium amounts for both part A and part B services from the inception of Medicare.

TABLE 2.—BENEFIT PAYMENTS BY SERVICE UNDER PART A AND PART B, FISCAL YEARS 1975, 1980, 1985, AND 1990

[Dollars in millions]

	1975		1980 percent	1985 percent	1990 (estimate) [1]		Projected average annual growth (1975–90)
	Amount	Percent			Percent	Amount	
Part A							
For inpatient hospital services	$9,947	70.5	67.4	64.3	54.4	$56,930	12.3
For skilled nursing facility services	273	1.9	1.1	0.8	0.7	730	6.8
For home health services	133	0.9	1.6	3.1	2.8	2,964	23.0
For hospice services	0	0.0	0.0	0.0	0.2	160	NA
Total benefit payments	10,353	73.3	70.1	68.2	58.0	60,784	12.5
Part B							
For physician services	3,067	21.7	23.0	24.5	29.3	30,664	16.6
For outpatient services	530	3.8	5.4	5.7	9.1	9,548	21.3
For other medical and health services	168	1.2	1.4	1.6	3.6	3,737	23.0
Total benefit payments	3,765	26.7	29.9	31.8	42.0	43,949	17.8
Total	14,118	100.0	100.0	100.0	100.0	104,733	14.3

[1] Represents projections of current law. Includes Adminstration regulations but not the legislative proposals. Also includes funding for the projections of peer review organizations.

Source: Health Care Financing Administration.

TABLE 3.—BENEFIT PAYMENTS BY SERVICE UNDER PART A AND PART B, FISCAL YEARS 1975 THROUGH 1989

[In millions of dollars]

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988 [1]	1989 [1]
PART A															
For inpatient hospital services	9,947	11,742	14,266	16,696	19,091	22,864	27,764	32,720	36,916	39,160	44,075	46,042	46,697	48,250	51,083
For skilled nursing facility services	273	308	351	354	363	387	428	462	511	535	567	568	591	616	670
For home health service	133	217	289	361	437	539	715	1,161	1,515	1,844	2,111	2,222	2,453	2,516	2,724
For hospice services	0	0	0	0	0	0	0	0	0	2	15	35	63	90	120
Total benefit payments	10,353	12,267	14,906	17,411	19,891	23,790	28,907	34,343	38,942	41,541	46,768	48,867	49,804	51,472	54,597
PART B															
For physician services	2,874	3,438	4,286	4,953	5,948	7,283	8,860	10,649	12,890	14,582	16,224	18,553	21,922	24,676	27,506
For radiology and pathology services	193	251	313	373	449	531	654	743	609	615	565	NA	NA	NA	NA
For outpatient service	530	745	988	1,230	1,496	1,847	2,248	2,916	3,346	3,533	3,903	4,925	5,793	6,795	8,097
For other medical and health services	168	238	280	296	366	483	583	498	642	743	1,116	1,691	2,217	2,641	3,129
Total benefit payments	3,765	4,672	5,867	6,852	8,259	10,144	12,345	14,806	17,487	19,473	21,808	25,169	29,932	34,112	38,732
Total	14,118	16,939	20,773	24,263	28,150	33,934	41,252	49,149	56,429	61,014	68,576	74,036	79,736	85,584	93,329

[1] Represents projections of current law. Includes Administration regulations but not the legislative proposals. Also includes funding for the peer review organizations.

NA—Not available.

Note: Physician services for 1986 through 1989 include radiology and pathology services.

Source: HCFA; Office of Management and Budget.

TABLE 4.—HISTORICAL AND PROJECTED AMOUNTS OF PART A (HOSPITAL INSURANCE) AND PART B (SMI) DEDUCTIBLE, COINSURANCE AND PREMIUMS [1]

For benefit periods begining in	Inpatient hospital [2]			Skilled nursing facility 21st thru 100th day coinsurance per day [5]	HI monthly premium [6]		SMI deductible	SMI premium	
	First 60 days deductible	61st thru 90th day coinsurance per day [3]	60 lifetime reserve days (nonrenewable) coinsurance per day [4]		Effective date	Amount		Effective date	Amount
1966	$40	$10	(7)	(7)			$50	7/66	$3.00
1967	40	10	(7)	$5.00			50		3.00
1968	40	10	$20	5.00			50	4/68	4.00
1969	44	11	22	5.50			50		4.00
1970	52	13	26	6.50			50	7/70	5.30
1971	60	15	30	7.50			50	7/71	5.60
1972	68	17	34	8.50			50	7/72	5.80
1973	72	18	36	9.00	7/73	$33	60	[8] 9/73	6.30
1974	84	21	42	10.50	7/74	36	60	7/74	6.70
1975	92	23	46	11.50	7/75	40	60		6.70
1976	104	26	52	13.00	7/76	45	60	7/76	7.20
1977	124	31	62	15.50	7/77	54	60	7/77	7.70
1978	144	36	72	18.00	7/78	63	60	7/78	8.20
1979	160	40	80	20.00	7/79	69	60	7/79	8.70
1980	180	45	90	22.50	7/80	78	60	7/80	9.60
1981	204	51	102	25.50	7/81	89	60	7/81	11.00
1982	260	65	130	32.50	7/82	113	75	7/82	12.20
1983	304	76	152	38.00		113	75		12.20
1984	356	89	178	44.50	1/84	155	75	1/84	14.60
1985	400	100	200	50.00	1/85	174	75	1/85	15.50

TABLE 4.—HISTORICAL AND PROJECTED AMOUNTS OF PART A (HOSPITAL INSURANCE) AND PART B (SMI) DEDUCTIBLE, COINSURANCE AND PREMIUMS [1]—Continued

For benefit periods begining in	Inpatient hospital [2]			Skilled nursing facility 21st thru 100th day coinsurance per day [5]	HI monthy premium [6]		SMI deductible	SMI premium	
	First 60 days deductible	61st thru 90th day coinsurance per day [3]	60 lifetime reserve days (nonrenewable) coinsurance per day [4]		Effective date	Amount		Effective date	Amount
1986	492	123	246	61.50	1/86	214	75	1/86	15.50
1987	520	130	260	65.00	1/87	226	75	1/87	17.90
1988	540	135	270	68.00	1/88	234	75	1/88	24.80
1989 [9]	552	138	276	69.00	1/89	240	75	1/89	28.00
1990 [9]	568	142	284	71.00	1/90	247	75	1/90	29.20
1991 [9]	584	146	292	73.00	1/91	254	75	1/91	30.40
1992 [9]	600	150	300	75.00	1/92	261	75	1/92	31.50

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[1] For services furnished on or after January 1, 1982, the coinsurance amounts are based on the inpatient hospital deductible for the year in which the services were furnished. For services furnished prior to January 1, 1982, the coinsurance amounts are based on the inpatient hospital deductible applicable for the year in which the individual's benefit period began.

[2] For care in psychiatric hospital—190 day lifetime limit.

[3] Always equal to ¼ of inpatient hospital deductible.

[4] Always equal to ½ of inpatient hospital deductible.

[5] Always equal to ⅛ of inpatient hospital deductible.

[6] Not applicable prior to July 1973. Applies to individuals who are not fully insured.

[7] Not covered.

[8] For August 1973 the premium was $6.10.

[9] Administration projections under current law using fiscal year 1989 budget assumptions.

Note: In addition to the deductible and coinsurance amounts shown in the table, the first 3 pints of blood are not reimbursed by Medicare. Currently there is no deductible or coinsurance on home health benefits. From January 1973 to June 30, 1982, there was a $60 annual deductible and prior to July 1, 1981, benefits were limited to 100 visits per benefit period under part A and 100 visits per calendar year under part B. Special limits apply to certain benefits: (1) Outpatient physician services for mental illness: 50 percent of approved charges; up to a maximum of $250 in benefits per year; (2) Physical therapy services furnished by physical therapists in independent practice: Maximum annual approved charges July 1, 1973, through December 31, 1981, $80 per year; January 1, 1982 through December 31, 1982, $400 per year, and January 1, 1983 and thereafter, $500 per year.

Source: Health Care Financing Administration, Office of the Actuary.

ADMINISTRATION

Responsibility for administration of the Medicare program has been delegated by the Secretary of Health and Human Services to the Administrator of the Health Care Financing Administration (HCFA). Much of the day-to-day operational work of the program is performed by "intermediaries" and "carriers" which have responsibility for reviewing claims for benefits and making payments.

In general, hospitals and other providers paid under part A of Medicare can nominate, subject to HCFA's approval, a national, State, or other public or private agency to serve as a fiscal intermediary between themselves and the Federal Government.

The Secretary enters into contracts with insurance organizations to serve as carriers. The carrier must perform its obligations under the contract efficiently and effectively and must meet such requirements as to financial responsibility, legal authority, and other matters as the Secretary finds pertinent. The carrier must ensure that payments made to providers under part B on a reasonable cost or reasonable charge basis (as may be applicable) are reasonable.

Medicare administrative costs amount to approximately 2.5 percent of program outlays.

Hospitals

The Social Security Amendments of 1983 (Public Law 98–21) altered the way in which Medicare pays hospitals. From the inception of the program, Medicare had paid hospitals on a "reasonable cost" basis. Effective October 1, 1983, Medicare began paying under a prospective payment system. Medicare payments for inpatient operating costs of hospitals are determined in advance and made on a per discharge basis. A fixed amount per case is paid based upon the type of case or "diagnosis-related group" (DRG) into which the case is classified.

The payment system is not applied to capital-related costs, direct medical education costs, and certain other costs. These expenses continue to be reimbursed on a reasonable cost basis. Capital costs may no longer be excluded from the system beginning October 1, 1991. Certain hospitals are excluded from the system: psychiatric, long-term care, children's and rehabilitation hospitals. Excluded hospitals continue to be paid based on reasonable costs subject to certain rate of increase limitations.

Additional payments are made for extraordinarily costly cases, for the indirect costs of medical education, and for hospitals serving a disproportionate share of low income patients. An adjustment is made for the wage level in the area in which the hospital is located. In addition, there are certain other exceptions and adjustments including those for sole community providers, national and regional referral centers, and cancer treatment centers.

The payment system will be phased in over 4 years from payments based on an individual hospital's historical costs to payments based on the new prospective payment rates. In addition, the system will be phased in from payments representing nine regional payment levels to one national payment level for each DRG. There will be separate payment levels for urban and rural areas.

Hospitals and other institutional providers receiving payment under Medicare part A submit bills on behalf of the beneficiary and agree to accept the program's payment as payment in full. In general, providers are permitted to charge beneficiaries only the deductible and coinsurance amounts authorized by law.

Physicians

Medicare part B provides insurance coverage for physician services and for certain services provided by other noninstitutional providers. To be entitled to benefits under Medicare part B, individuals eligible for hospital benefits under part A must enroll in part B and pay a monthly premium.

Payments are made for services covered under part B after an annual deductible requirement of $75 has been satisfied. Payment is set at 80 percent of the Medicare approved "reasonable" charge. Beneficiaries are responsible for the remaining 20 percent as coinsurance.

For physicians' services, the Medicare approved reasonable charge is limited to the lowest of the following amounts: (1) the physician's actual charge for the service; (2) the physician's customary charge for the service; or (3) the prevailing charge for the service as provided by physicians in a particular locality. Since 1973, annual increases in prevailing charge levels have been limited by the Medicare Economic Index (MEI). The index reflects year-to-year changes in general wage levels and physician practice costs. Customary and prevailing charge screens generally are updated every year. However, payments were temporarily frozen from July 1, 1984 to December 31, 1986.

In limited situations, the Secretary of Health and Human Services may make an adjustment in payment levels if he determines that application of the standard payment methodology results in a payment level that is not "inherently reasonable." Standards and procedures for application of the inherent reasonableness authority are specified by statute. Based on similar considerations, Congress has required a reduction in payment for cataract surgery and related anesthesia services effective January 1, 1987, and has required reductions in certain other procedures effective April, 1, 1988.

Medicare payment is made either on an "assigned" or "unassigned" basis. By accepting assignment, physicians agree to accept the Medicare approved charge as payment-in-full. Thus, if assignment is accepted, beneficiaries are not liable for any out-of-pocket costs other than standard deductible and coinsurance payments. In contrast, if assignment is not accepted, beneficiaries may be liable for charges in excess of the Medicare approved charge.

Medicare's participating physician program was established in 1984 to provide beneficiaries with the opportunity to select a physician who has agreed to accept assignment on all services provided during a 12-month period. Nonparticipating physicians continue to be able to accept or refuse assignment on a claim-by-claim basis. A number of incentives are provided to encourage physicians to sign participation agreements. These include: higher prevailing charge screens, more rapid claims payment, and wide-spread distribution of participating physician directories.

To ensure that limitations on Medicare payments do not result in higher out-of-pocket costs for beneficiaries, the actual charges of nonparticipating physicians are limited during a 4-year period beginning on January 1, 1987. Under the maximum allowable actual charge (MAAC) limits, nonparticipating physicians with actual charges in excess of 115 percent of the prevailing charge are limited to a 1 percent a year increase in their actual charges. Nonparticipating physicians with lower actual charges may increase their charges at a more rapid rate. (Additional information concerning physician payment is included in appendix E.)

The following table shows the number of participating institutions and organizations.

TABLE 5.—PARTICIPATING INSTITUTIONS AND ORGANIZATIONS (JUNE 1984 AND 1987)

	1984	1987
Hospitals	6,675	6,734
Short stay	6,038	5,895
Long stay	637	839
Skilled nursing facilities	5,952	7,262
Home health agencies	4,684	5,887
Independent laboratories	3,801	4,381
Outpatient physical therapy providers	791	977
Portable X-ray suppliers	269	374
Rural health clinics	420	451
Comprehensive outpatient rehabilitation facilities	48	124
Ambulatory surgical centers	155	765
Hospices	108	390
Facilities providing services to renal disease beneficiaries	1,335	1,645
Hospitals certified as both renal transplant and renal dialysis centers	147	153
Hospitals certified as renal transplant centers	16	38
Hospital dialysis facilities	117	147
Non-hospital renal dialysis facilities	645	914
Dialysis centers only	359	350
Inpatient care	51	43
Hospital and skilled nursing facility beds (June 1984 and 1987)		
Hospitals	1,144,142	1,136,287
Short stay	1,023,465	1,007,841
Long stay	120,677	128,446
Skilled nursing facilities	530,403	[1] 444,326

[1] As of January 1987. Participating Medicare—Only.

Source: Health Care Financing Administration.

END STAGE RENAL DISEASE PROGRAM

In 1972, Public Law 92-603 was signed extending Medicare coverage for certain individuals with chronic renal failure. The Medicare program covers individuals, under age 65, who suffer from end stage renal disease, if they are (1) fully insured for old age and survivor insurance benefits, or (2) are entitled to either monthly social security benefits, or (3) are spouses or dependents of individuals described in (2). Such persons must be medically determined to be suffering from end stage renal disease and must file an application for benefits. Approximately 7 percent of the population suffering from end stage renal disease (ESRD) does not meet any of these requirements and thus are not covered for Medicare renal benefits.

Benefits for qualified end stage renal disease beneficiaries include all part A (hospital insurance) and part B (supplementary medical insurance) medical items and services. ESRD beneficiaries are automatically enrolled in the part B portion of Medicare and must pay the monthly premium for such protection.

TABLE 6.—ESRD MEDICARE BENEFICIARIES AND PROGRAM EXPENDITURES

[Expenditures in millions]

Year	Expenditures	Beneficiaries	Per person
1974	$229	15,993	$14,300
1975	361	22,674	15,900
1976	512	28,941	17,700
1977	641	35,889	17,900
1978	800	43,482	18,400
1979	1,010	52,636	19,200
1980	1,250	60,814	20,600
1981	1,472	68,288	21,500
1982	1,650	75,097	22,000
1983	1,889	81,873	23,100
1984	2,100	87,000	24,200
1985	2,300	92,000	25,400
1986	2,099	104,000	20,181
1987	2,674	126,309	21,170
1988	2,932	133,887	21,899
1989	3,150	140,694	22,389
1990	3,449	146,950	23,471
1991	3,740	152,524	24,521
1992	4,030	157,334	25,614
1993	4,318	162,054	26,645

Note: Projections for 1985–93 are subject to revision by the Office of Financial and Actuarial Analysis; projections for 1988–93 are under the fiscal year 1989 budget assumptions.

Source: Office of Financial and Actuarial Analysis, Health Care Financing Administration, Department of Health and Human Services.

Table 6 shows program expenditures, number of beneficiaries, and the average expenditure per person from 1974 to projected expenditures and beneficiaries through 1993. Total projected program expenditures for Medicare end stage renal disease program for fiscal year 1988 amount to $2.9 billion. In fiscal year 1988, there are projected to be 134,000 ESRD beneficiaries including successful transplant patients, and also including persons entitled to Medicare on the basis of disability who also have ESRD.

Outpatient maintenance dialysis can be provided in either a hospital-based setting or independent (often called freestanding) setting.

Until 1983, payment for maintenance dialysis under Medicare had been based on cost-based principles in the case of outpatient dialysis care furnished by hospitals and on the basis of "reasonable" or allowed charges in the case of services provided by independent (or freestanding) dialysis treatment facilities.

In 1981, the Congress passed Public Law 97-35 which required the Secretary to establish dual, or separately calculated, prospective rates for hospital-based and for freestanding facilities. Congress expressed a preference that these formulas be composite in nature, that is, they take into account the proportions of hospital-based and independent facility patients dialyzing at home and the relative costs of providing dialysis at home and in the facility setting.

Under the regulations in effect prior to October 1, 1986, before any exceptions are taken into account, the average (base) payment rate under the prospective payment system was $127 per treatment for independent facilities and $131 per treatment for hospital units, regardless of whether the treatment is furnished in the facility or in the patient's home. Public Law 99-509 provided, effective October 1, 1986, that payment rates were to be reduced to $125 and $129 respectively. The Secretary must maintain the reduced rates for 2 years but is authorized to change the rates thereafter. The exception process was also liberalized. The payment rates are adjusted by an area wage index to take into account differences in the local labor costs of dialysis facilities so that the actual payment rates (without any adjustments for exceptions) may vary above and below the average payment rates established for hospital-based and independent dialysis units. The new prospective payment system was implemented as of August 1, 1983.

Kidney transplants are covered for Medicare beneficiaries. The costs incurred by the kidney donor are reimbursed by Medicare even if the donor is not a Medicare beneficiary. Medicare reimburses more than 90 percent of the kidney transplants performed in the United States. Table 7 shows the numbers of transplants performed in Medicare-certified hospitals.

TABLE 7.—TOTAL KIDNEY TRANSPLANTS PERFORMED IN MEDICARE CERTIFIED U.S. HOSPITALS

Calendar year	Total transplants	Living donor		Cadaveric donor	
		Number	Percent	Number	Percent
1979	4,189	1,186	28	3,003	72
1980	4,697	1,275	27	3,422	73
1981	4,883	1,458	30	3,425	70
1982	5,358	1,677	31	3,681	69

TABLE 7.—TOTAL KIDNEY TRANSPLANTS PERFORMED IN MEDICARE CERTIFIED U.S. HOSPITALS—Continued

Calendar year	Total transplants	Living donor		Cadaveric donor	
		Number	Percent	Number	Percent
1983	6,112	1,784	29	4,328	71
1984	6,968	1,704	24	5,364	76
1985	7,695	1,876	24	5,819	76
1986	8,976	1,887	21	7,089	79

HOME HEALTH

The hospital insurance (part A) and the supplementary medical insurance (part B) programs cover home health services without a deductible or coinsurance charge. There is no limitation on the number of home health visits covered under the home health program, and there is no prior hospitalization requirement. When an individual is covered under parts A and B of the Medicare program, the individual will generally receive payment for home health services under part A of the program.

Reimbursement to home health agencies is based on Medicare rules for reasonable cost reimbursement. However, home health agencies are required to use the cost per visit by type of service for apportioning costs. Under this method, the total allowable costs of all visits for each type of service (skilled nursing, home health aide, etc.) is divided by the total number of visits by type of service. These average cost per visit amounts are multiplied by the number of covered Medicare visits for each type of service. The products represent the cost Medicare will recognize by type of service, subject to home health agency cost limits.

Cost limits for home health agencies were set at the 75th percentile of average per visit costs. Though the limits were established by type of service, they were applied to each agency as a single aggregate limit based on the number of visits for each type of service.

Public Law 97–248 required the Secretary to establish a single reimbursement limit for home health agencies based on the cost experience of freestanding home health agencies. In establishing the single limits, the Secretary was required to make adjustments, as appropriate, for hospital-based home health agencies based on legitimate cost differences resulting from such factors as a more complex case mix and the effects of Medicare cost allocation requirements. The single limits were published on July 2, 1984. An "add on" for hospital based facilities was provided.

The Administration, in revised final regulations published on July 5, 1985, established the following home health visit methodology: For cost-reporting periods beginning on or after July 1, 1985, the limits are set at 120 percent of the mean and are applied separately to each type of service. For cost reporting periods beginning on or after July 1, 1986, the limits are reduced to 115 percent of the mean, and for visit reporting periods beginning on or after July 1, 1987, the limits are set at 112 percent of the mean.

However, in 1986, the Congress passed Public Law 99-509 which amended the Secretary's authority to establish limits for home health costs to require that limits again apply on an aggregate basis for all home health services, rather than on a discipline of specific basis, for cost reporting periods beginning on or after July 1, 1986.

Until recently the Medicare home health benefit was the fastest growing part of the Medicare program. Table 8 below indicates the increase in Medicare program expenditures for home health care.

TABLE 8.—TOTAL MEDICARE HOME HEALTH BENEFIT PAYMENTS

[Dollars in millions] [1]

	Reimbursements			Percent change	Visits per 1,000 enrollees [2]	Average charge per visit [2]
	Part A	Part B	Total			
1969	NA	NA	$81	....	424	$10
1970	NA	NA	63	−22.7	291	12
1971	NA	NA	57	−8.8	226	13
1972	NA	NA	66	15.7	241	14
1973	NA	NA	93	40.9	265	15
1974	NA	NA	139	48.6	340	17
1975	NA	NA	215	551	431	20
1976	NA	NA	297	38.1	520	22
1977	NA	NA	371	24.9	597	25
1978	NA	NA	443	19.4	639	27
1979	NA	NA	542	22.4	717	30
1980	NA	NA	666	22.9	792	33
1981	NA	NA	860	29.1	902	36
1982	NA	NA	1,121	30.3	1,060	40
1983	NA	NA	1,425	27.1	1,252	43
1984	NA	NA	1,897	33.1	1,343	50
1985	2,111	53	2,164	14.1	1,324	54
1986	2,222	44	2,266	4.7	1,303	58
1987	2,153	35	2,488	9.8	1,306	60
1988	2,516	40	2,556	2.7	1,310	63
1989	2,724	45	2,769	8.3	1,315	66
1990	2,964	51	3,015	8.9	1,321	70
1991	3,204	57	3,261	8.2	1,328	74
1992	3,458	63	3,521	8.0	1,337	78
1993	3,719	71	3,790	7.6	1,345	82

[1] Based on fiscal year 1989 budget assumptions, supplied by HCFA; Office of Management and Budget.

[2] Based on Part A alone.

NA=Not available.

Source: HCFA/Bureau of Data Management and Statistics.

HOSPICE CARE

Public Law 97-248 authorized Medicare part A coverage for hospice care services provided to individuals who are entitled to Medicare part A benefits and who are certified to be terminally ill. In 1986, the Congress in Public Law 99-272 made the hospice benefit a permanent part of the Medicare program effective April 7, 1986.

On December 16, 1983, the Health Care Financing Administration (HCFA), published regulations to implement the hospice provisions of Public Law 97-248. Among other things, the regulations establish requirements for eligibility, covered benefits, services, reimbursement procedures, and the conditions a hospice must meet to be approved for participation in the Medicare program.

Part A beneficiaries may elect to receive hospice care in lieu of most other Medicare benefits for up to two periods of 90 days each, plus an additional 30 days.

The statute provides that payment to hospice providers be equal to the costs which are reasonable and related to the cost of providing hospice care, or which are based on such other tests of reasonableness as the Secretary may prescribe, subject to a "cap amount." The cap amount for a beneficiary for a year was established at $6,500, adjusted annually by the Medical component of the CPI. The cap for fiscal year 1988 is $7,898.

HCFA has implemented a prospective payment methodology for hospice care. Under this methodology, hospices would be paid one of several predetermined rates for each day a Medicare beneficiary is under the care of the hospice. The rates vary according to the level of care furnished to the beneficiary. Total reimbursement to a hospice for care furnished to the Medicare beneficiary will vary by the length of the patient's period in the hospice program as well as by the characteristics of the services (intensity and site) furnished to the beneficiary.

The regulations established four basic payment categories. The payment rates are national rates which are adjusted by the Bureau of Labor Statistics wage index for an area. The published payment rates are:

(a) *Routine home care day.*—Routine home care day is a day on which an individual who has elected to receive hospice care is at home and is not receiving continuous home care. The routine home care rate would be paid for every day a patient is at home and under the care of the hospice regardless of the volume or intensity of the services provided on any given day as long as less than 8 hours of care are provided. Public Law 99-272 increased the national rate to $63.17.

(b) *Continuous home care day.*—A continuous home care day is a day on which an individual who has elected to receive hospice care receives hospice care consisting predominantly of nursing care on a continuous basis at home. Home health aide or homemaker services or both may also be provided on a continuous basis. Continuous home care is furnished only during brief periods of crisis and only as necessary to maintain the terminally ill patient at home. Home care would have to be provided for a period of at least 8 hours before it would be considered to fall within the category of continuous home care.

Payment for continuous home care will vary depending on the number of hours of continuous services provided. Public Law 99-272 increased the national payment rate to $368.67 for 24 hours of continuous home care.

(c) *Inpatient respite care day.*—An inpatient respite care day is one on which the individual who has elected hospice care receives care in an approved facility on a short-term (not more than 5 days at a time) basis for the respite of his caretakers. Public Law 99-272 increased the national payment rate to $65.33.

(d) *General inpatient care day.*—A general inpatient care day is one on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings. Care may be provided in a hospital, skilled nursing facility or inpatient unit of a freestanding hospice. Public Law 99-272 increased the national payment rate to $281.00.

Public Law 98-617 also required the Secretary of HHS to review and adjust the hospice rates annually, beginning October 1, 1985. According to the Secretary, cost data were not available in order for the rates to be updated.

TABLE 9.—MEDICARE HOSPICE PROGRAM DATA

Period	Number of facilities	Number of admissions	Total dollars (in millions)	Reimbursement per admission
11/01/83-09/14/84	119	2,098	$3.5	$1,646
11/01/83-12/19/84	153	3,800	7.0	1,834
11/01/83-04/30/85	171	7,549	16.0	2,117
11/01/83-07/31/85	200	11,014	23.5	2,137
11/01/83-09/30/85	233	14,874	33.8	2,272
11/01/83-10/31/86	279	34,865	102.2	2,930
11/01/83-10/31/87	417	91,475	278.3	3,042

Data derived from Hospice Status Report, Health Care Financing Administration.

SKILLED NURSING FACILITY

In general, skilled nursing facilities are reimbursed on the basis of reasonable costs subject to certain limits.

Reimbursement limits for skilled nursing facilities have been established for inpatient general routine service costs. Limits are set at 112 percent of the average labor-related and average non-labor related costs of each comparison group.

The Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248) required the Secretary to establish a single payment limit for both freestanding and hospital-based skilled nursing facilities (SNFs) based on the cost experience of freestanding facilities, subject to adjustments for hospital-based SNFs deemed appropriate. The provision was to be effective October 1, 1982. The Social Security Amendments of 1983 (Public Law 98-21) postponed the effective date for 1 year. This provision was further modified in Public Law 98-369 (the Deficit Reduction Act of 1984). The law provides that for cost reporting periods beginning on or after October 1, 1982, and prior to July 1, 1984, hospital-based facilities and free-standing facilities would be reimbursed on the same basis used to calculate reimbursement limits that had been in effect prior to the passage of the Tax Equity and Fiscal Responsibility Act (i.e., reverting to prior law). For cost reporting periods beginning on or after July 1, 1984, separate limits would continue to be established for freestanding facilities in urban and rural areas at 112 percent of the mean operating costs of urban and rural freestanding facilities, respectively. Limits for urban or rural hospital-based facilities would be set at the appropriate freestanding facility limit plus 50 percent of the difference between the freestanding facility limit and 112 percent of the mean operating costs of hospital-based facilities. Adjustments to take into account administrative costs for hospital based facilities would be allowed as an add on. Final regulations were issued April 1, 1986.

In addition, Public Law 98-21 required the Secretary to report by December 31, 1983, on the effect of the implementation of the TEFRA single-rate provision on hospital-based SNFs, given the difference (if any) in the patient populations served by such facilities and by freestanding SNFs. Further, the Secretary was required to report by the end of 1983 on the impact of hospital prospective payment on SNFs. This report was received January 18, 1985.

Public Law 99-272 established a prospective payment rate system for certain SNFs that elect such payment for cost reporting periods beginning on or after October 1, 1986. SNFs providing less than 1,500 days of care per year to Medicare patients in the preceding year would have the option of being paid a prospective payment rate set at 105 percent of the regional mean for all SNFs in the region. The rate is to be separately calculated for urban and rural areas and the prospective per diem rate also is to reflect wage differences between urban and rural areas within each region. These rates cannot exceed the per diem cost limit that would otherwise be applicable to that facility and cannot exceed its cost limit adjusted for capital costs.

TABLE 10.—SKILLED NURSING FACILITY DATA

Fiscal year	Number of SNF facilities	Total covered days of care (thousands)	Total interim reimbursement (thousands)	Interim reimbursement per day
1977	4,461	9,757.7	314,149	32
1978	4,982	9,231.5	317,505	34
1979	5,055	8,643.7	329,498	38
1980	5,155	8,644.2	356,633	41
1981	5,295	8,581.2	390,408	45
1982	5,510	8,564.2	420,644	49
1983	5,760	9,100.3	458,854	50
1984	6,183	9,209.5	475,802	52
1985	6,725	8,070.4	457,400	57
1986[1]	7,065	7,742.4	492,969	64

[1] Data are considered preliminary.

Data derived from Medicare Statistical System (MSS), Current Utilization Series Table 8, 11/27/87 Update, BDMS.

UTILIZATION AND QUALITY CONTROL PEER REVIEW PROGRAM

The Social Security Amendments of 1972 provided for the establishment of Professional Standards Review Organizations (PSRO's) throughout the country which were charged with the comprehensive and on-going review of services provided under Medicare, Medicaid, and the maternal and child health programs. PSRO's determined, for purposes of reimbursement under these programs, whether services are: (1) Medically necessary, (2) provided in accordance with professional standards, and (3) in the case of institutional services, rendered in the appropriate setting.

The Tax Equity and Fiscal Responsibility Act of 1982 repealed the existing PSRO program and established a new program. Under this new program, a Peer Review Organization (PRO) is defined as an entity which is either composed of a substantial number of the licensed doctors of medicine and osteopathy practicing in the area or has available to it sufficient numbers of such physicians so that adequate peer review of various medical services can be assured.

The PRO program is similar to the PSRO program with the following important distinctions. Under the new program, eligible organizations may be either for-profit or non-profit and may be either physician groups or have available to them sufficient physicians to perform review. The Secretary is required to consolidate existing PSRO geographic areas. Each State has been designated as a single area, plus the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa (54 PRO's). The Secretary is required to enter into a contract with a peer review organization for each geographic area. Priority consideration must be given to physician-sponsored organizations; payor organizations were excluded from participation until October 1, 1984. Contracts with provider or provider-affiliated organizations are prohibited though subcontracts with such entities are permitted. As of January 1, 1985, the Secretary had entered into agreements with 53 physician-sponsored organizations and one fiscal intermediary. The law provides that contracts are for an initial period of 2 years, renewable biennially. Contracts with PRO's must specify objectives to be achieved for each PRO over the contract period. Performance will be rated in terms of meeting these goals.

These entities may review, subject to the provisions of the contracts, the professional activities of physicians, other practitioners and institutional and noninstitutional providers in rendering services to Medicare beneficiaries. The review is to focus on the necessity and reasonableness of care, quality of care, and the appropriateness of the setting. The determinations of the peer review organizations would ordinarily be binding for purposes of determining whether benefits should be paid.

States are authorized to contract with review organizations for Medicaid review and 75 percent Federal matching is authorized for such purpose.

Hospitals were required to sign an agreement with a PRO in the area on or before November 15, 1984, as a condition of receiving payment under the Medicare program.

FINANCING

Background

The Medicare part A Hospital Insurance Trust Fund (HI) finances inpatient hospital, skilled nursing facility, home health and other institutional services. The part B Supplementary Medical Insurance Trust Fund (SMI) finances principally physician and hospital outpatient services.

The Hospital Insurance Trust Fund is financed primarily through Social Security payroll tax contributions paid by employers, employees and the self-employed. The payroll tax rate for calendar year 1987 was 1.45 percent of earnings up to $43,800 per employee, and for 1988 it is 1.45 percent up to $45,000 per employee. An equal contribution rate is paid by the employer. Table 11 shows the contribution rates and maximum taxable earnings for both HI and the old-age, survivors and disability insurance (OASDI) programs.

TABLE 11.—CURRENT LAW SOCIAL SECURITY PAYROLL TAX RATES FOR EMPLOYERS AND EMPLOYEES EACH AND TAXABLE EARNINGS BASES

Calendar year	Employee and employer rates, each (percent)			Taxable earnings base	Maximum HI tax
	OASDI combined	HI	OASDHI combined		
1977	4.95	0.90	5.85	$16,500	$148.50
1978	5.05	1.10	6.05	17,700	194.70
1979	5.08	1.05	6.13	22,900	240.45
1980	5.08	1.05	6.13	25,900	271.95
1981	5.35	1.30	6.65	29,700	386.10
1982	5.40	1.30	6.70	32,400	421.20
1983	5.40	1.30	6.70	35,700	464.10
1984	5.70	1.30	7.00	37,800	491.40
1985	5.70	1.35	7.05	39,600	534.60
1986	5.70	1.45	7.15	42,000	609.00
1987	5.70	1.45	7.15	43,800	635.10
1988	6.06	1.45	7.51	45,000	652.50
1989	6.06	1.45	7.51	(1)	(1)
1990 and after	6.20	1.45	7.65	(1)	(1)

[1] The maximum earnings subject to the tax increases each year in accordance with the increase in average earnings.

As table 12 demonstrates, the bulk of the financing for HI is derived from payroll taxes. In 1989, there will be transferred an estimated $346 million from the railroad retirement fund. This is the estimated amount that would have been in the fund if railroad employment had always been covered under the Social Security Act.

HI benefits are provided to certain uninsured persons aged 65 or over. Such payments are made initially from the HI Trust Fund, with reimbursement from the general fund of the Treasury for the costs, including administrative expenses, of the payments. Approximately $458 million will be transferred to HI during 1989 on this basis.

Certain persons not eligible for HI protection either on an insured basis or on the uninsured basis described in the previous paragraph may obtain protection by enrolling in the program and paying a monthly premium ($234 in 1988). This accounts for $55 million of financing in fiscal year 1989.

Sections 217(g) and 229(b) of the Social Security Act, prior to modification by the Social Security Amendments of 1983, authorized annual reimbursement from the general fund of the Treasury to the HI Trust Fund for costs arising from the granting of deemed wage credits for military service prior to 1957, according to quinquennial determinations made by the Secretary of Health and Human Services. These sections, as modified by the Social Security Amendments of 1983, provided for a lump sum transfer in 1983 for costs arising from such wage credits. In addition, the lump sum transfer included combined employer-employee HI taxes on the noncontributory wage credits for military service after 1965 and before 1984. After 1983, HI taxes on military wage credits are credited to the fund on July 1 of each year. The Social Security Amendments of 1983 also provided for (1) quinquennial adjustments to the lump sum amount transferred in 1983 for costs arising from pre-1957 deemed wage credits and (2) adjustments as deemed necessary to any previously transferred amounts representing HI taxes on noncontributory wage credits. In 1989, this accounts for $95 million of income to the HI trust fund.

The remaining $5,829 million of receipts consisted almost entirely of interest on the investments of the trust fund and interest on interfund borrowing.

TABLE 12.—INCOME TO THE HOSPITAL INSURANCE AND SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS FOR SELECTED FISCAL YEARS

[Dollars in millions]

	Fiscal year						1989 percent of total financing
	1970 [1]	1975 [1]	1980	1985	1988 [2]	1989 [2]	
Hospital insurance:							
Payroll taxes	$4,785	$11,291	$23,244	$46,490	$60,544	$64,094	56.4
Transfers from railroad retirement account	64	132	244	371	351	346	.3
Reimbursement for uninsured persons	617	481	697	766	475	458	.4
Premiums from voluntary enrollees	0	6	17	38	50	55	([3])
Payments for military wage credits	11	48	141	86	93	95	.1
Interest on investments and other income	137	609	1,072	3,182	4,971	5,829	5.1
Total	5,614	12,568	25,415	50,933	66,484	70,877	62.3
Supplementary medical insurance:							
Premiums	936	1,887	2,928	5,524	8,536	9,551	8.4
General revenues	928	2,330	6,932	17,898	25,152	32,697	28.8
Interest and other income	12	105	415	1,155	540	556	.5
Total	1,876	4,322	10,275	24,577	34,228	42,804	37.7
Grand total—HI and SMI	7,490	16,890	35,690	75,510	100,712	113,681	100.0

[1] For fiscal years 1970 and 1975, the interval is from July 1 to June 30.

[2] Based upon alternative II–B assumptions.

[3] Less than 0.1.

Source: 1987 Annual Reports of the Board of Trustees of the Federal Hospital Insurance and Supplementary Medical Insurance Trust Funds.

Part B, which is voluntary, is financed from premiums paid by the aged, disabled and chronic renal disease enrollees and from the general revenues. The premium rate is derived annually based upon the projected costs of the program for the coming year. Under prior law, the premium rate was changed on July 1 of each year. The Social Security Amendments of 1983 (Public Law 98-21) moved the premium increase date to January 1 of each year to coincide with the changed date for the annual Social Security cash benefit cost-of-living (COLA) increase.

Ordinarily, the premium rate is the lower of: (1) an amount sufficient to cover one-half of the costs of the program for the aged or (2) the current premium amount increased by the percentage by which cash benefits were increased under the COLA provisions of the Social Security program. Premium income, which originally financed half of the costs of part B, had declined—as a result of this formula—to less than 25 percent of total program income.

The Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248), temporarily suspended the COLA limitation for 2 years—calendar years 1984 and 1985. During this period, enrollee premiums will be allowed to increase to amounts necessary to produce premium income equal to 25 percent of program costs for elderly enrollees. The Deficit Reduction Act of 1984 (Public Law 98-369) extended the TEFRA provision through calendar years 1986 and 1987. The 1987 Reconciliation bill (Public Law 100-203) extended the provision through 1989. The premium beginning January 1, 1988, is $24.80 per month.

As Table 12 illustrates for the SMI trust fund, approximately $9.6 billion will be collected in premiums during fiscal year 1989, with a general revenue transfer of $32.7 billion. Interest and other income accounted for the remaining $.6 billion of income.

FINANCIAL STATUS OF THE TRUST FUNDS

The Hospital Insurance Trust Fund balances are dependent upon the income to the HI trust fund primarily through payroll taxes exceeding the outlays for Medicare benefits and administrative costs. Outlays are affected by increases in inpatient hospital expenditures which have been rising at a faster rate than the income to the HI trust fund. Table 13 shows the percentage increase in Medicare outlays from fiscal year 1967 to fiscal year 1987 and the Congressional Budget Office (CBO) and HCFA projections from 1988 to 1993. According to the CBO, hospital costs attributable to Medicare beneficiaries are projected to increase over the 1989-93 period at an average annual rate of 9.8 percent, while income is projected to grow at an annual rate of 8.0 percent.

TABLE 13.—MEDICARE OUTLAYS, FISCAL YEARS 1967–93

Fiscal year	Part A		Part B		Total	
	Dollars (in millions)	Percent increase (over prior year)	Dollars (in millions)	Percent increase (over prior year)	Dollars (in millions)	Percent increase (over prior year)
1967	2,597	....	799	....	3,396	....
1968	3,815	46.9	1,532	91.7	5,347	57.4
1969	4,758	24.7	1,840	20.1	6,598	23.4
1970	4,953	4.1	2,196	19.3	7,149	8.4
1971	5,592	12.9	2,283	4.0	7,875	10.2
1972	6,276	12.2	2,544	11.4	8,820	12.0
1973	6,842	9.0	2,637	3.7	9,479	7.5
1974	8,065	17.9	3,283	24.5	11,348	19.7
1975	10,612	31.6	4,170	27.0	14,782	30.3
1976 [1]	12,579	18.5	5,200	24.7	17,779	20.3
1977	15,207	20.9	6,342	22.0	21,549	21.2
1978	17,862	17.5	7,356	16.0	25,218	17.0
1979	20,343	13.9	8,814	19.8	29,157	15.6
1980	24,288	19.4	10,737	21.8	35,025	20.1
1981	29,260	20.5	13,228	23.2	42,488	21.3
1982	34,864	19.2	15,560	17.6	50,424	18.7
1983	38,624	10.8	18,311	17.7	56,935	12.9
1984	42,108	9.0	20,372	11.3	62,480	9.7
1985	48,654	15.5	22,730	11.6	71,384	14.3
1986	49,685	2.1	26,217	15.3	75,902	6.3
1987	50,803	2.3	30,837	17.6	81,640	7.6
CBO projections						
1988	53,672	5.6	35,173	14.1	88,845	8.8
1989	57,535	7.2	39,757	13.0	97,292	9.5
1990	64,148	11.5	45,095	13.4	109,243	12.3
1991	70,067	9.2	51,386	14.0	121,453	11.2
1992	76,760	9.6	58,401	13.7	135,161	11.3
1993	83,700	9.0	66,259	13.5	149,959	10.9
HCFA projections						
1988	52,484	3.3	35,173	14.1	87,657	7.4
1989	55,782	6.3	40,026	13.8	95,808	9.3
1990	61,985	11.1	45,298	13.2	107,283	12.0
1991	67,989	9.7	51,535	13.8	119,524	11.4
1992	74,214	9.2	58,834	14.2	133,048	11.3
1993	80,434	8.4	66,993	13.9	147,427	10.8

[1] In the transition quarter from July to October 1976 (when the beginning of the Federal fiscal year was changed), outlays were $4,805 million. These outlays do not appear in the table.

Source: 1987 Annual Report of the Board of Trustees: Federal Hospital Insurance Trust Fund and Supplementary Medical Insurance Trust Fund and CBO and HCFA, Office of Management and Budget projections for 1988 through 1993 under current law.

Supplementary medical insurance

Because the Supplementary Medical Insurance (SMI) Trust Fund is financed through beneficiary premiums and the general revenues, it does not face the prospect of depletion as does the HI trust fund. However, the rapidly rising cost of health care is placing a heavy burden on the SMI trust fund—causing beneficiary premiums to rise and increasing the Federal deficit. CBO estimates that SMI outlays will increase at an annual rate of 13.5 percent from 1987 through 1993.

HI trust fund income, outlays, and balance

Table 14 shows the projections of the Congressional Budget Office and the administration for the HI trust funds with respect to income, outlays and balances for the years 1987 through 1993.

TABLE 14.—PROJECTIONS FOR THE HOSPITAL INSURANCE TRUST FUND, INCOME AND OUTLAYS, BY CBO AND ADMINISTRATION UNDER PRESENT LAW

[In billions]

	1987	1988	1989	1990	1991	1992	1993
CBO baseline:							
Total outlays	50.8	53.7	57.5	64.1	70.1	76.8	83.7
Income [1]	62.7	67.8	72.9	79.0	85.3	91.6	99.0
Year-end-balance	50.6	64.7	80.1	95.0	110.2	125.2	140.4
Start of year balance, as percent of outlays	76	94	113	125	136	143	149
Administration:							
Total outlays	50.8	52.5	55.8	62	68	74.2	80.4
Income [1]	62.7	67.9	72.8	78.6	84.4	89.9	95.9
Year-end-balance	50.6	66	83	99.6	116	131.7	147.1
Start of year balance, as percent of outlays	76	96	118	134	146	156	164

[1] Income to the trust funds is budget authority. It includes payroll tax receipts, interest on balances, and certain general fund transfers.

Source: Congressional Budget Office and HCFA, Office of Management and Budget.

Sensitivity of HI trust funds balances to different outlay growth assumptions

Table 15 presents alternative projections of Hospital Insurance (HI) trust fund outlay growth through 1993. All of these projections assume the economic projections underlying the baseline path. The alternatives all are arranged in the table from least to most growth. Hospital outlays are projected to grow by 1 or 2 percent less and 1 or 2 percent more than the baseline in each year. These changes could be due to variations in hospital rate increases, admission patterns, intensity or change in case mix, or technology changes. The percentage refers to entire hospital outlays and not just those outlays covered by the prospective payment system.

Income to the trust fund is the same (except for interest which varies by size of trust fund balance) in each projection. Under the least growth alternative, expenditures are $76.3 billion in fiscal year 1993 compared to $83.7 billion in the baseline projection. Trust fund balances are $23 billion greater in this alternative.

Conversely, under the alternative with the most growth, expenditures are $7.9 billion higher and trust fund balances $24 billion smaller in 1993 as compared to the baseline projection.

TABLE 15.—ALTERNATIVE PROJECTIONS OF HOSPITAL INSURANCE OUTLAY GROWTH AND YEAR-END BALANCES [1]

[By fiscal year, in billions of dollars]

	1986 [2]	1987 [2]	1988	1989	1990	1991	1992	1993
2 percent lower outlays:								
Outlays	49.7	50.8	53.7	56.5	61.8	66.3	71.3	76.3
End-of-year balance	38.6	50.6	64.7	81.2	98.6	118.0	139.2	163.2
1 percent lower outlays:								
Outlays	49.7	50.8	53.7	57.0	63.0	68.2	74.0	79.9
End-of-year balance	38.6	50.6	64.7	80.7	96.9	114.3	132.4	152.2
Baseline:								
Outlays	49.7	50.8	53.7	57.5	64.1	70.1	76.8	83.7
End-of-year balance	38.6	50.6	64.7	80.1	95.0	110.2	125.1	140.4
1 percent higher outlays:								
Outlays	49.7	50.8	53.7	58.1	65.3	72.0	79.6	87.6
End-of-year balance	38.6	50.6	64.7	79.5	93.2	106.2	117.8	128.6
2 percent higher outlays:								
Outlays	49.7	50.8	53.7	58.6	66.5	74.0	82.5	91.6
End-of-year balance	38.6	50.6	64.7	79.0	91.3	102.2	110.5	116.5

[1] Projections assume economic assumptions underlying CBO's baseline path.

[2] Actual.

Source: Congressional Budget Office.

Projections beyond 1990

Longer-term projections of trust fund balances depend on many different assumptions. Factors such as changes in PPS rates, number of beneficiaries, admission rates, and others will affect trust fund outlays. Also, the extent to which the complexity of diagnosis has grown and might continue to grow would increase outlays, by how much is difficult to estimate. Finally, forecasting changes in medical technology and their implications for spending is very difficult.

In the absence of CBO projections beyond 1993, committee staff extrapolated the lastest CBO projections from 1993 to 2010. This extrapolation was done by assuming that the average rate of growth in outlays for the last 2 years of CBO's baseline projections would remain the same through 2010. A similar assumption was made with respect to income. These results are shown in table 16.

The projections in table 16 indicate that insolvency of the HI trust fund is postponed until 2009. This represents a substantial improvement compared to last year. Under these committee staff extrapolations of CBO projections, the HI fund is exhausted in 2009 under the baseline path; 2003 under a 1 percent higher outlay growth rate than assumed in the baseline path; and after 2012 under a 1 percent lower growth rate in outlays relative to the baseline. These projections indicate solvency has been lengthened by ten years compared to similar baseline projection made a year ago.

TABLE 16.—PROJECTIONS OF HI OUTLAY AND TRUST FUND BALANCES TO FISCAL YEAR 2010 BASED UPON CBO'S JANUARY 1988, PROJECTIONS [1]

[In billions of dollars]

Fiscal year	Baseline path		Baseline path, assuming 1 percent lower annual growth		Baseline path, assuming 1 percent higher annual growth	
	Outlays	Yearend balance	Outlays	Yearend balance	Outlays	Yearend balance
January 1988, estimates:						
1990	64	95	63	97	65	93
1995	100	170	94	192	107	143
2000	156	216	140	303	174	104
2005	243	157	208	438	284	(191)
2010	379	(175)	310	598	464	(1,095)
Year trust fund exhausted		2009		NA		2003

[1] Projections for fiscal years 1988 through 1993 assume economic assumptions used in CBO's baseline. Projections for fiscal years 1994–2012 are made by committee staff using the average of the growth rates for outlays in the last 2 years of CBO's baseline estimate (1991–1992 and 1992–1993).

Long-range estimates

Long-range estimates for the next 25 years are shown in table 17 for the HI program and are based on the alternative II–B assumptions of the 1987 HI Trustees' report. As in the case of the OASDI program, annual expenditures as a percentage of taxable earnings are shown in table 17 as the cost rate. The income rate is simply the combined scheduled HI tax rate for employees and employers.

The average deficit over the 25-year period is 0.44 percent of taxable earnings. Last year, this deficit was estimated to be 0.66 percent of taxable earnings.

TABLE 17.—ESTIMATED LONG-RANGE HI ANNUAL COST RATE, ANNUAL INCOME RATE, AND ACTUARIAL BALANCE

[Percent of taxable payroll]

	Expenditures under the program [1]	Trust fund building and maintenance [2]	Total cost of the program [3]	Tax rate scheduled in the law [4]	Difference
Calendar year:					
1987	2.57	0.33	2.90	2.90	0
1988	2.63	.27	2.90	2.90	0
1989	2.73	.17	2.90	2.90	0
1990	2.84	.06	2.90	2.90	0
1995	3.22	−.32	2.90	2.90	0
2000	3.48	.03	3.51	2.90	−0.61
2005	3.73	.02	3.75	2.90	−.85
2010	4.01	.01	4.02	2.90	−1.12
25-year average: 1987–2011	3.39	−.05	3.34	2.90	−.44

[1] Costs attributable to insured beneficiaries only. Benefits and administrative costs for noninsured persons are financed through general revenue transfers and premium payments, rather than through payroll taxes. Gratuitous credits for military service after 1956 are included in taxable payroll.

[2] Allowance for building and maintaining the trust fund balance at the level of a half year's outgo after accounting for the offsetting effect of interest earnings.

[3] Totals do not necessarily equal the sum of rounded components.

[4] Rates for employees and employers combined.

Note: The above estimates are based on the 1987 alternative II–B assumptions.

Source: Office of the Actuary, Health Care Financing Administration.

REAL MEDICARE DISBURSEMENTS PER ENROLLEE

Table 18 shows that the rate of growth in spending for Medicare has declined over the decade, an effect that is more readily apparent after eliminating the effects of general inflation. On a per enrollee basis, annual growth in real costs from 1985 through 1989 will be an estimated 3.0 percent, compared to an annual growth rate of 7.2 percent from 1980 through 1985.

The falling rate of growth in spending for Medicare is primarily due to lower growth in hospital inpatient costs. These changes were coincident with restraints enacted in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA-82) and with implementation (under the Social Security Amendments of 1983) of the prospective payment system and a new peer review mechanism for hospital care. Another major factor was the large increase in the inpatient deductible.

In addition, there was a decline in the rate of growth in spending for home health and skilled nursing care, due apparently to more stringent criteria used by HI intermediaries to distinguish between allowed and disallowed services.

Trends in the rate of growth in spending for hospital outpatient services and for services provided by independent laboratories are more variable, due in part to shifts in costs from other spending categories. Outpatient department costs have grown rapidly thoughout the period, for example, partly because technological advances have made it possible to provide a growing number of procedures on an outpatient basis that could formerly be safely provided only on an inpatient basis, where costs are typically higher. As another example, the very large rate of growth in 1985 for services provided by independent labs resulted from provisions of DEFRA-84. Under this bill, physicians were prohibited from billing for services provided by independent laboratories, so that these costs were shifted from the physician category to the lab category, with perhaps some attendant savings due to elimination of middle-man profit for physicians.

TABLE 18.—REAL MEDICARE DISBURSEMENTS PER ENROLLEE, FISCAL YEARS 1980, 1985 AND 1989

[In 1988 dollars]

	1980	1985	1989	Average annual growth rate (percent)		
				1980–89	1980–85	1985–89
Total Medicare	1,807	2,557	2,877	5.3	7.2	3.0
Benefits	1,750	2,495	2,820	5.4	7.4	3.1
Administration	57	62	58	0.2	1.7	−1.7
Hospital insurance (HI) benefits	1,218	1,703	1,671	3.6	6.9	−0.5
Supplementary medical insurance (SMI) benefits	532	792	1,148	8.6	8.3	9.7
By benefit category: [1]						
A. Hospital insurance (HI):						
1. Inpatient	1,171	1,607	1,568	3.3	6.5	−0.6
2. SNF	20	20	20	0.0	0.0	0.0
B. Home health (HI and SMI)	39	76	82	8.5	14.3	1.9
C. Supplementary medical insurance (SMI):						
1. Physician [2]	420	631	882	8.6	8.5	8.7
2. Outpatient hospital	95	142	242	11.0	8.4	14.3
3. Independent lab	6	18	24	17.4	24.6	7.5

[1] Hospice benefits are not shown. It was $0 per enrollee in 1980 and 1985, and $3 in 1989.

[2] Including group practice plans.

Note.—The implicit price deflator for gross national product (GNP) is used to obtain constant dollars.

Source: Congressional Budget Office using Health Care Financing Administration data for 1980 and 1985; Congressional Budget Office projections for 1989.

RECENT LEGISLATIVE CHANGES

Summarized in tables 19–24 are the legislative changes made in Medicare in 1981, 1982, 1983, 1984 and 1986. The changes were incorporated in the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35), the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248), the Social Security Amendments of 1983 (Public Law 98-21), Deficit Reduction Act of 1984 (Public Law 98-369), Hospice Care Amendments (Public Law 98-617), the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272) and the Omnibus Budget Reconciliation Act of 1986 (Public

Law 99-509). Table 19 in section 1 of Part 5 contains the budget estimates for Medicare provisions enacted into law during 1987.

The annual savings have not been totaled because of the differences in underlying economic assumptions in each year's estimates. In addition, some of the provisions have not yet been implemented.

These tables are primarily useful as a short legislative history of when certain changes were enacted. The numbers illustrate the expected savings either at the time of enactment or shortly thereafter. Increasingly, it is becoming clear that these savings estimates, particularly for hospital and physician reimbursement, are not accurate.

Also, in examining table 24, these estimates are made relative to a baseline which assumed the DRG rate of increase was 0.5 percent and the periodic interim payments were eliminated for all hospitals except small rural hospitals.

The major legislative changes enacted in 1986 (Public Law 99-509) and in 1987 (Public Law 100-203) are described in the section following table 23.

TABLE 19.—CONGRESSIONAL BUDGET OFFICE [1] REVISED ESTIMATES FOR LEGISLATIVE CHANGES MADE IN CALENDAR YEAR 1981 (OMNIBUS BUDGET RECONCILIATION ACT OF 1981)

[In millions of dollars]

January 1982 estimates	Fiscal year—		
	1982	1983	1984
Provisions affecting hospital insurance:			
Making part A deductible and coinsurance more current	−185	−305	−360
Less frequent SNF surveys [2]	−4	−4	−4
Repeal of temporary delay in periodic interim payments	−692	0	0
Making part A coinsurance current with the year in which services are furnished	−5	−10	−10
Set section 223 limits on reimbursements to hospitals at 108 percent	−75	−105	−125
Limit nursing differential to 5 percent	−95	−105	−130
Elimination of occupancy test for hospital long-term care	−70	−80	−90
Set section 223 limits on reimbursement to home health agencies at 45th percentile	−12	−23	−27
PSRO modifications	−5	−8	−5
Payments to promote closing and conversion of underutilized facilities [2]	−2	−7	−19
Elimination of need for occupational therapy as a basis for entitlement to home health services	−23	−27	−31
Eliminate reimbursement for free-standing alcohol detoxification facilities	(3)	(3)	(3)
Total—Hospital insurance	−1,168	−674	−801
Provisions affecting supplementary medical insurance:			
Increase in part B deductible and elimination of carryover from previous year	−175	−265	−295
Civil money penalties	−7	−7	−7
Elimination of unlimited open enrollment	−9	−10	−11
Limitation on reasonable charge for outpatient services	−15	−23	−27
Incentive reimbursement rate for renal dialysis services [4]	−105	−130	−155
Medicare payments secondary in cases of end-stage renal disease (revenue increase)	−95	−165	−180
Total—Supplementary medical insurance	−406	−600	−675
Total HI and SMI	−1,574	−1,274	−1,476

[1] This table reflects estimates from the Congressional Budget Office which show the impact of the legislative changes enacted during 1981. The numbers are not extremely sensitive to economic conditions. Thus any changes to the numbers from earlier estimates represent different assumptions.

[2] As of January 1, 1985, the provision had not been implemented.

[3] Negligible.

[4] CBO and Administration estimate that was used during the 1981 reconciliation process.

Note: Minus (−) indicates an expenditure reduction or revenue increase, plus (+) indicates an expenditure increase or revenue decrease.

TABLE 20.—CONGRESSIONAL BUDGET OFFICE[1] REVISED OUTLAY ESTIMATES FOR LEGISLATIVE CHANGES MADE IN CALENDAR YEAR 1982 (TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982)

[In millions of dollars]

January 1983 estimates	Fiscal year—				
	1983	1984	1985	1986	1987
Medicare secondary for older workers	−88	−265	−451	−680	−780
80 percent radiologist/pathologist (medicaid cost of $90 million)	−150	−210	−245	−280	−315
Elimination of nursing differential	−95	−110	−125	−145	−165
Hospital-based physicians	−6	−40	−75	−110	−125
Part B premium as a constant percentage of costs (medicaid cost of $155 million)	−35	−240	−550	−600	−650
Hospital reimbursement changes[1] (medicaid savings of $460 million)	−895	−2,380	−4,610	−3,060	−1,740
Elimination of private room subsidy	−35	−75	−80	−85	−90
Single reimbursement limit for skilled nursing facilities and home health agencies	−20	−53	−62	−69	−77
Elimination of duplicate payments for outpatient services	−75	−135	−175	−210	−255
Audit and medical claims review	−85	−215	−215	−130	0
Temporary delay in periodic interim payments	−750	−100	870	0	0
Reimbursement of assistants at surgery	−24	−63	−113	−170	−195
Prohibition of payments for ineffective drugs	0	0	0	0	0
Medicare payments to HMO's	0	0	0	0	0
Technical corrections	0	0	0	0	0
Hospice care	1	1	−16	−40	0
Coverage of extended care services	0	0	0	0	0
Percentage arrangements (not for hospital-based physicians)	0	−17	−20	−23	−26
Prohibit payment for Hill-Burton care	−15	−17	−20	−23	−26
Prohibiting payment for antiunionization activities	0	0	0	0	0
Lesser of cost or charges	0	0	0	0	0
Extend medicare proficiency exam	0	0	0	0	0
Access to books and records	0	0	0	0	0
Private sector utilization review	0	0	0	0	0
Part B enrollment	(2)	(2)	(2)	(2)	(2)
Subtitle C—Utilization and quality control peer review	0	−15	−20	−20	−25
HI tax for Federal employees (outlay savings)	−116	−160	−174	−195	−207
Total medicare provisions	−2,388	−4,094	−6,081	−5,840	−4,676

[1] Assumes the "target" reimbursement system is not extended after 3 years.

[2] Negligible cost.

TABLE 21.—CONGRESSIONAL BUDGET OFFICE OUTLAY AND INCOME ESTIMATES FOR LEGISLATIVE CHANGES MADE IN CALENDAR YEAR 1983 (THE SOCIAL SECURITY AMENDMENTS OF 1983)

[In millions of dollars]

	1983	1984	1985	1986	1987	1988
Supplementary medical insurance:						
Medicare premium delay:						
SMI	113	63	−90	−202	−206	−211
HI	1	(1)	(1)	(1)	(1)	(1)
Hospital insurance outlays:						
Pass through mandatory FICA	0	150	224	150	38	7
Prospective payment system	0	0	0	(2)	(2)	(2)
Delay SNF reimbursement limit	20	22	5	3	3	4
Lower return on equity capital	−10	−90	−100	−100	−40	0
DRG Commission	0	[3] 1	[3] 2.4	[3] 3	[3] 3	[3] 3
Total HI outlay changes	10	83	132	56	4	14
Hospital insurance income:						
SECA tax increase	0	377	1,262	1,434	1,605	1,670
Cover nonprofit organizations	0	216	326	397	480	605
State speedup	0	140	10	10	10	10
Military transfer credits	3,290	−70	−70	−60	−60	−60
Total HI income changes	3,290	663	1,528	1,781	2,035	2,225
Total outlay and income infusions to HI Trust Fund	3,280	580	1,396	1,725	2,031	2,211
Estimated HI Interest Income	44	386	499	634	765	902
Total annual increase in HI Trust Fund	3,324	966	1,895	2,359	2,796	3,113

[1] Less than $0.5 million.

[2] The budgetary impact cannot be estimated because the law allows the Secretary of HHS, as advised by a panel of experts, nearly unlimited discretion in setting payment rates for inpatient hospital services. Those rates could be set such that aggregate medicare outlays would increase or decrease.

[3] This provision is subject to appropriation. For fiscal year 1984, the appropriation was $1.5 million.

Source: CBO estimates based on January 1983 economic assumptions.

TABLE 22.—CONGRESSIONAL BUDGET OFFICE OUTLAY IMPACT FOR LEGISLATIVE CHANGES MADE IN CALENDAR YEAR 1984

[In millions of dollars]

June 1984 estimates	Fiscal year—			
	1984	1985	1986	1987
Delay implementation of single limit for SNF's	20	30	35	40
Hospital rate of increase	0	0	−180	−250
Establish fee schedule for clinical lab services	−40	−240	−300	−380
(Medicaid)	(−10)	(−49)	(−57)	(−67)

TABLE 22.—CONGRESSIONAL BUDGET OFFICE OUTLAY IMPACT FOR LEGISLATIVE CHANGES MADE IN CALENDAR YEAR 1984—Continued

[In millions of dollars]

June 1984 estimates	Fiscal year—			
	1984	1985	1986	1987
Hepatitis B vaccine	3	−1	−2	−2
Physician fee freeze	−40	−720	−840	−950
(Medicaid)	(0)	(−14)	(−16)	(−18)
Limitation on certain foot services	−3	−11	−11	−12
Part B premium increase	0	0	−384	−884
Premium decrease due to other savings	0	187	246	288
(Medicaid)	(0)	(−14)	(10)	(45)
Revaluation of assets	−2	−25	−45	−70
Competitive contracting	0	−15	−25	−33
Lesser of costs and charges	0	−45	−55	−65
Coinsurance for DME	−5	−20	−25	−25
Working aged	0	−260	−380	−415
Payment rate for routine home care under hospice program (Public Law 98–617)	0	1	3	0
Medicare total	−67	−1,306	−1,825	−2,162
(Medicaid total)	(−10)	(−77)	(−63)	(−40)
Premium totals	0	187	−138	−596
Total Medicare provisions	−77	−1,196	−2,026	−2,798

Note: Savings are from legislation made in the Deficit Reduction Act of 1984, Public Law 98–369 except where noted.

TABLE 23.—ESTIMATED BUDGET IMPACT OF COBRA RECONCILIATION PROVISIONS, BY PROVISION (P.L. 99–272)

[In millions]

	Fiscal year—					
	1986	1987	1988	1989	1990	1991
Limit hospital increase	65	170	190	210	240	260
Delay transition	−45	−255	0	0	0	0
Lower indirect GME adjustment to 8.7 percent	−180	−580	−850	−1,100	−1,250	−1,350
Disproportionate share (create disproportionate share adjustment, lower indirect GME adjustment to 8.1 percent, and restandardize DRG rates in 1987 and 1988)	95	0	0	0	0	0
Reduce return on equity	0	−40	−110	−190	−280	−360

TABLE 23.—ESTIMATED BUDGET IMPACT OF COBRA RECONCILIATION PROVISIONS, BY PROVISION (P.L. 99–272)—Continued

[In millions]

	Fiscal year—					
	1986	1987	1988	1989	1990	1991
Indirect teaching adjustment for Mayo Clinic	4	0	0	0	0	0
Payments for sole community	2	5	5	5	5	5
Access to SNF's	0	15	35	35	35	35
GME direct	25	−60	−135	−165	−205	−250
Limiting penalty for part A	1	5	5	5	5	5
Working aged	−90	−349	−385	−443	−503	−562
Audit and medical claims review	−101	−144	−141	9	9	9
Physician fee freeze	−195	−300	−360	−350	−285	−95
Premiums increase	0	0	−464	−516	−547	−581
Payments for assistants at surgery	−15	−27	−25	−30	−29	−34
Prosthetic lens for cataract	−20	−35	−38	−42	−49	−52
Preventive care demos	1	1	1	0	0	0
Clinical lab	−10	12	22	22	27	37
Total Medicare	−463	−1,582	−2,250	−2,550	−2,827	−2,933

TABLE 24.—ESTIMATED BUDGET IMPACT OF OBRA RECONCILIATION PROVISIONS, BY PROVISION (P.L. 99–509)

[In millions]

	Fiscal year—		
	1987	1988	1989
Change in part A deductible	420	720	720
Payments for inpatient hospital services	230	−520	−675
Capital payments	−155	−355	−590
Puerto Rico on prospective payment	0	0	0
Quality of care—part A	38	50	47
Disproportionate share for rural hospitals	0	0	0
Technical and miscellaneous amendments—part A	0	0	0
PIP/prompt pay	625	815	315
HMO amendments	25	50	45
Quality of care—parts A and B	4	7	7
Direct costs of graduate medical education	0	0	0
Home health limits	20	15	20
Establish research programs	6	7	8
Civil penalties	0	0	0
Organ procurement	0	−35	25
Medicare secondary payer	−190	−255	−275
Nurse anesthetists	0	0	0
Technical and miscellaneous amendments—parts A and B	0	0	0

TABLE 24.—ESTIMATED BUDGET IMPACT OF OBRA RECONCILIATION PROVISIONS, BY PROVISION (P.L. 99-509)—Continued

[In millions]

	Fiscal year—		
	1987	1988	1989
Physician payments	30	40	25
Inherent reasonableness/cataract surgery	−110	−155	−175
End stage renal disease payments	55	75	35
Vision care	35	60	70
Occupational therapy	5	20	20
Physician assistants	0	0	0
Clinical labs	−7	−54	−72
Payment for nutrition supplies	−25	−35	−40
Medicare appeal rights	4	8	8
Alzheimer's demo projects	14	14	14
Ambulatory surgery	−5	−45	−75
Technical and miscellaneous amendments—part B	0	0	0
Improved PRO reviews	9	16	18
Total	1,028	513	−525

1987 LEGISLATIVE CHANGES

THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987

Part A provisions

1. *Hospital prospective payment rates.*—The act sets the fiscal year 1988 update at 1.5 percent for PPS hospitals in urban areas greater than 1 million, 3.0 percent for PPS hospitals in rural areas, and 1.0 percent for other PPS hospitals; and sets the fiscal year 1989 update at market basket minus 2.0 percentage points for hospitals in urban areas greater than 1 million, market basket minus 1.5 percentage points for rural hospitals, and market basket minus 2.5 percentage points for other hospitals. The act sets the update factor at the market basket rate of increase for all PPS hospitals in fiscal year 1990 and later years.

For PPS-exempt hospitals, the annual increase for reporting periods beginning in fiscal year 1988, excluding the first 51 days of such periods is set at 2.7 percent, and the annual increases for fiscal year 1989 and fiscal year 1990 are set equal to the projected increase in the market basket.

The legislation establishes a regional floor on payments to PPS hospitals during a 3-year period and requires a ProPAC analysis of hospital nonlabor costs and input prices. The act also reduces the indirect medical education adjustment to 7.70 percent and removes the existing 15 percent cap on additional payments to disproportionate share hospitals effective Oct. 1, 1988. In addition, the act increases the disproportionate share adjustment to 25 percent for hospitals which qualify based upon their receiving more than 30 percent of their net revenues from public sources. The act requires that ProPAC analyze the desirability of adjusting the nonlabor portion of hospital payments based upon the input prices which hospitals face in purchasing goods and services.

2. *Rural hospitals.*—The act revises standards for including an adjacent rural county in an urban area, expands the swing bed program to rural hospitals with up to 100 beds, expands availability of payment adjustments for small and isolated rural hospitals with declining admissions, changes the definition of rural referral centers to include all rural hospitals with more than 275 beds, and authorizes $15 million per year in fiscal years 1988-90 to fund rural demonstration projects restricted to nonprofit hospitals.

3. *Payments for capital.*—The act reduces payments for capital costs by 12 percent in fiscal year 1988 effective Jan. 1, 1988, and by 15 percent in fiscal year 1989; requires payment for capital on a prospective basis beginning Oct. 1, 1991; and excludes capital from PPS until then.

4. *Extension of reductions under sequester order.*—The act provides that reductions in payments under the Nov. 20, 1987 sequester order shall continue for all hospital services until Mar. 31, 1988, and for other part A services until Dec. 31, 1987.

5. *Hospital reporting.*—The act requires the Secretary to create a new data base for the hospital reporting system utilizing information from hospitals with cost reporting periods beginning during the first 4 months of the Federal fiscal year. The act also requires the Secretary to conduct a 2-year demonstration program using a new hospital reporting format in two States.

6. *Delay in effective date for requiring hospital protocols for organ procurement.*—The act delays the date by which the Secretary must complete designation of organ procurement agencies until Mar. 31, 1988.

7. *Miscellaneous and technical provisions relating to part A.*—The act increases the maximum civil monetary penalty for violation of Medicare requirements regarding emergency cases to $50,000; delays recoupment of any overpayments which may have been made to certain hospitals under sec. 1886(c) State waiver authority for 1 year; clarifies the sec. 1814(b) State waiver authority; prohibits the Secretary from making a change in policy or method regarding bad debt recognition for hospital services; increases payments for outlier cases classified in DRG's relating to burns; amends prior law regarding a miscellaneous accounting provision; requires, under certain conditions, that the Secretary determine that a pediatric hospital meets the criteria of a Medicare heart transplant facility; extends indefinitely the current waiver of certain inpatient requirements for Connecticut Hospice, Inc.; revises the appointment process for the Prospective Payment Assessment Commission; requires the Secretary to prepare a rural regulatory impact analysis for any rule or regulation that may have significant impact on small rural hospitals; clarifies that part A covers the inpatient hospital services of clinical psychologists; modifies Medicare's conditions of participation related to individuals responsible for care of a Medicare patient; and clarifies that hospitals which qualify for disproportionate share status based upon the per-

centage of their revenues derived from State and local government sources do so based upon their net revenues.

Part A and B provisions

1. *Payment standards.*—The act requires fiscal intermediaries to hold claims for 10 days after the date of receipt during the last 3 months of fiscal year 1988 and for 14 days during fiscal year 1989.

2. *Health maintenance organization (HMO) reforms.*—The act broadens the use of sanctions and civil monetary penalties against HMO's and CMP's, provides for extended supplemental coverage for enrollees of an HMO which terminates its contract, and requires HMO's to notify new enrollees of the possibility that the contract will be terminated in the future. The HMO's option to have Medicare pay directly for hospital services is eliminated, while the option to deposit Medicare payments in a benefit stabilization fund is extended until 1990. The prohibition of physician incentive payments is delayed for 1 year, to April 1990. The waivers for social health maintenance organizations are extended, and other waivers are provided for a variety of organizations in special circumstances.

Finally, the act provides for new capitation demonstrations to test revisions in the rate-setting process and requires a General Accounting Office report on rate methodologies. The administration is permitted to carry out its proposal for demonstrations of contracts with employer-related groups, subject to special restrictions.

3. *Publication of policies.*—The act includes a number of provisions to improve communications between the Secretary, fiscal intermediaries and carriers, and providers. Significant policy changes would be required to be promulgated as regulations, and providers of home health care and other extended services would receive prompt notice of other policy decisions.

4. *Coverage of the disabled.*—The act provides that disabled beneficiaries who cease to receive Social Security disability insurance and who regain disability coverage after a period of employment may resume Medicare coverage without another 2-year waiting period.

5. *Home health care quality improvements.*—The act establishes new conditions of participation and new survey procedures for home health care providers. Exceptions, including leaving home for medical treatment, are created to the requirement that an individual be confined to home in order to be eligible for home health care. A new procedure for appeal of determinations of eligibility for home health care or other extended care is established, along with a toll-free hotline and investigative unit for beneficiary problems. The act includes a demonstration of prospective payment for home health care. It also delays the Secretary's authority to make certain program changes, including requiring prior authorization for extended care and deeming privately accredited agencies as eligible providers.

6. *Other provisions.*—The act also: (1) makes technical changes in the ESRD program and requires a report on the program from the Secretary; (2) clarifies that government entities are the primary payers for disabled employees who are Medicare beneficiaries; (3) delays the Secretary's plan to use administrative law judges em-

ployed by the Health Care Financing Administration, rather than those in the Social Security Administration, to hear Medicare appeals; and (4) establishes rural health medical education demonstration projects.

Part B

1. *Sequester and delay in update.*—The act continues the sequester through Mar. 31, 1988. The physician payment update is delayed until Apr. 1, 1988.

2. *Physician payments.*—The act provides that for the 9-month period beginning Apr. 1, 1988, the increase in the Medicare economic index for participating physicians is 3.6 percent for primary care services and 1 percent for other physicians' services. For nonparticipating physicians, the increase is 3.1 percent for primary care services and 0.5 percent for other services.

For physicians' services furnished in 1989, the percentage increase for participating physicians is 3.0 percent for primary care services and 1.0 percent for other services. For nonparticipating physicians, the increase is 2.5 percent for primary care services and 0.5 percent for other services.

The act provides for a 5-percent incentive payment for primary care services furnished by physicians in class I or II rural health manpower shortage areas effective Jan. 1, 1989. Urban health manpower shortage areas would be included in 1991.

3. *Overpriced procedures.*—The act provides for a 2-percent across-the-board reduction in the prevailing charges for selected overpriced procedures plus an additional reduction of between 0 and 15 percent for physicians in areas with prevailing charges between 85 and 150 percent of the national average effective Apr. 1, 1988. In no case would prevailing charges be reduced below 85 percent of the national average.

The following are the procedures for which reductions are made: Coronary artery bypass surgery; total hip replacement; cataract surgery; transurethral prostatectomy; suprapubic prostatectomy; dilation and curettage; carpal tunnel repair; pacemaker surgery; bronchoscopy; upper gastrointestinal endoscopy; knee arthroscopy; and knee arthroplasty.

The act also limits Medicare reimbursement for ophthalmic ultrasound procedures to 5 percent of the prevailing charge for cataract surgery with intraocular lens implantation.

4. *New physicians.*—The act sets the customary charge for new physicians at 80 percent of the prevailing charge. The provision does not apply to primary care services or to services furnished in rural health manpower shortage areas.

5. *Anesthesia/radiology.*—The act reduces payments to anesthesiologists for concurrent supervision of certified registered nurse anesthetists. It establishes a fee schedule for radiology services provided by board-certified and board-eligible radiologists or by physicians whose charges for radiologic services account for 50 percent or more of their Medicare charges.

6. *Clinical labs.*—The act makes the following changes to clinical laboratory provisions. There would be no fee schedule update for 1988. The differential between hospital outpatient labs and independent labs would be eliminated except for sole community hospi-

tals. Fee schedule allowances for automated tests and tests subject to the lowest charge provision (except for cytopathology tests) would be reduced by 8.3 percent. The nationwide limit on fee schedule allowances would be reduced to 100 percent of the median of carrierwide fee schedules effective Apr. 1, 1988. The act also establishes intermediate sanctions for labs which no longer substantially meet the conditions of participation for clinical laboratories and requires quality certification of high-volume physician office labs effective in 1990.

7. *Durable medical equipment.*—The act establishes a 1-year freeze on durable medical equipment payment screens effective Jan. 1, 1988, at the levels in effect on Dec. 31, 1987. Beginning in 1989 a new payment mechanism, based on fee schedules, is established for durable medical equipment, prosthetic devices, orthotics, and prosthetics.

8. *Payments to hospital outpatient departments for radiology.*—The act contains a limit on aggregate payments for hospital outpatient radiology departments based on payment screens for comparable services provided in physicians' offices.

9. *Coinsurance for ambulatory surgery.*—The act does not include an increase in the part B deductible. It does include restoration of beneficiary cost sharing for physician services provided in ambulatory surgical centers.

10. *Part B premium.*—The act extends for 1 year through calendar year 1989 the current 25 percent payment provision.

11. *Influenza.*—The act directs the Secretary to conduct a major demonstration project to evaluate the cost effectiveness of providing influenza vaccines to aged Medicare beneficiaries.

12. *Therapeutic shoes.*—The act provides for a demonstration project concerning coverage of therapeutic shoes for individuals with diabetic foot disease.

13. *Mental health.*—The act increases the maximum payment for mental health services to $450 in 1988 and $1,100 in 1989.

Medicare and Medicaid nursing home standards reform

1. *Nurse staffing.*—The act retains Medicare's current law nurse staffing and registered nurse requirements and waiver provisions applying to the RN requirement. For Medicaid, the act requires as of Oct. 1, 1990, that all SNF's and ICF's, in urban and rural areas, provide 24-hour licensed practical nurse care 7 days a week, with at least one RN employed 7 days a week, 8 hours a day. The act authorizes States to waive the RN and LPN requirements if (1) the institution demonstrates to the satisfaction of the State that it has been unable, despite diligent efforts (including offering wages at the prevailing rates at other nursing facilities), to recruit appropriate personnel, and (2) the State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the institution. The act also authorizes the Secretary to exercise States' authority to grant such waivers if the Secretary finds, based on a clear pattern and practice of allowing waivers in the absence of diligent efforts, that a State had abused its discretion.

2. *Social workers.*—The act requires facilities with more than 120 beds to employ full-time at least one social worker (with at least a

bachelor's degree in social work or similar professional qualifications).

3. *Nurse aide training.*—The act requires nurse aides to complete a training and competency evaluation or separate competency evaluation program. Nursing facilities may not use an individual as a nurse aide after Jan. 1, 1990, who has not completed or is enrolled in such a program approved by the State. The Secretary's standards for nurse aide training must include a minimum of 75 hours of initial training.

4. *Activities program professionals.*—The act requires that the facility's on-going program of activities be directed by a qualified professional.

5. *Nursing facility administrators.*—The act requires the Secretary to establish standards for nursing facility administrators.

6. *Transfers and discharge requirements.*—The act applies transfer and discharge requirements to all transfers and discharges.

7. *Nurse aide registry.*—The act requires establishment of a nurse aide registry and that the State provide through the survey and certification agency for a process for the investigation of allegations of resident neglect and abuse (including the misappropriation of personal funds) by a nurse aide. A nurse aide so accused would be granted an opportunity for a hearing before the State survey and certification agency. No nurse aide's name would be placed on the registry until the individual had been notified of the right of a hearing, and either a hearing had taken place and the allegations had been substantiated, or the individual had waived, after being given a reasonable opportunity, his/her right to a hearing.

8. *Survey and certification.*—The act expands the standard survey to include a review of residents' rights and requires the Secretary to conduct validation surveys with respect to no fewer than 5 percent of the facilities surveyed by the State in a year, but in no case less than five facilities in a State.

9. *Enforcement.*—The act establishes Federal and State intermediate sanctions and provides that only Federal intermediate sanctions be applied to Medicare skilled nursing facilities.

Peer review organization provisions

The act authorizes 3-year PRO contract periods with staggered expiration dates; requires that a preliminary notice of denial be sent to providers and practitioners 20 days before a denial could become effective; requires publication in the Federal Register of specified information on PRO contracts; encourages competition for contracts held by out-of-State PRO's which are subject to renewal; prohibits physicians, in the case of assigned claims, from billing Medicare beneficiaries for payments denied on substandard quality grounds; requires PRO's, in establishing review standards, to take into account the special problems associated with delivering care in remote rural areas, the availability of service alternatives to inpatient hospitalization, and social factors that could adversely effect the safety or effectiveness of outpatient treatment; requires PRO's to perform substantial on-site review in 20 percent of the rural hospitals in the PROs' areas; requires PRO's to meet several times each year with hospital medical and administrative staff about PRO review; requires PRO's to determine whether health maintenance organizations or competitive medical plan enrollees have adequate access to health care services, and to require beneficiary outreach programs; requires that initial PRO review of psychiatric and physical rehabilitation services be made by physicians with corresponding specialties; requires the Secretary to establish demonstration projects on instruction and oversight through video communications; entitles providers or practitioners, in rural health manpower shortage areas and in counties with a population of less than 70,000, to a hearing before an administrative law judge prior to temporary exclusion from the Medicare program for reasons of substandard quality; and requires the Secretary to report to Congress on improving procedures for imposing sanctions.

1986 Legislative Changes

THE OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (OBRA)

1. *Inpatient Hospital Deductible.*—Limits the inpatient part A hospital deductible to $520 for calendar year 1987. For each succeeding calendar year the deductible would change by the same percentage change that applies to the medicare hospital prospective payment rates (adjusted for real case mix).

2. *Rate of Increase.*—Increase the fiscal year 1987 payment rates for PPS and PPS-exempt hospitals by 1.15 percent and increases the fiscal year 1988 payment rates by the market basket minus 2 percent. The Secretary would be required to recalibrate the DRG relative weights annually. The Secretary must provide a report with recommendations on the fiscal year 1988 update factors for PPS and PPS-exempt hospitals by April 1, 1987, and each March 1, thereafter.

Effective October 1, 1986, as separate urban and separate rural set-aside factor for outliers would be established.

Effective October 1, 1987, the methodology for computing the urban and rural averages would be revised to reflect the operating cost per discharge for the average patient as opposed to the average hospital.

Hospitals designated as regional referral centers as of the date of enactment would be permitted to continue their designation for 3 additional years. Criteria for eligibility for regional referral center status would be established by law.

3. *Payments for Capital-Related Costs.*—Payment amounts for capital-related payments for PPS hospitals would be reduced by 3.5 percent for portions of cost reporting periods in fiscal year 1987, 7 percent for fiscal year 1988, and 10 percent for fiscal year 1989. Sole community hospitals would be exempt from payment reductions, and regulations, if provided, for a period of 3 years. The conference agreement clarifies that the Secretary may incorporate capital, on a "budget neutral" basis, into the prospective payment system effective October 1, 1987.

4. *Coverage of Hospitals in Puerto Rico in the PPS.*—Hospitals located in Puerto Rico will be included in PPS, effective with discharges occurring on or after October 1, 1987. Payment amounts would be based on 75 percent of Puerto Rico adjusted standardized amount and 25 percent of the national adjusted standardized amount. Requires the Secretary to calculate an average standard-

ized amount for urban and rural hospitals. The Secretary would be required to restandardize the national PPS rates to take into account Puerto Rico's inclusion. With some adjustments applied, payments for indirect medical education costs, outliers, and disproportionate share payments will be made to a similar extent that they apply to other PPS hospitals.

5. *Improving Quality of Care with respect to Part A Services.*—The Secretary would be required to submit, no later than 2 years after enactment, a legislative proposal to improve the classification and payment system under PPS to better account for severity of illness and case complexity.

Hospitals would be required to provide, upon admission, a notice of hospital discharge rights. Would require hospitals, as a condition of medicare participation, to have a discharge planning program. Would require the Secretary to conduct a study of standards of quality used for the conditions of medicare participation for hospitals. The Secretary would be required to conduct a study to determine if a payment should be made for administratively necessary days.

Favorable presumption of waiver of liability rules would be extended for hospices through November 1, 1988. The favorable presumption of waiver of liability will be extended to cover homebound and intermittent care denials for home health services.

Would require the Secretary to develop a uniform needs assessment instrument that evaluates functional capacity to be used in evaluating the need for post-hospital care services.

Would extend the requirement for PPS annual reports through 1989. Would require the Secretary to include information on quality of post-hospital care in the annual reports.

The Secretary will be required to conduct a demonstration program concerning prior authorization for medicare skilled nursing facilities and home health services.

6. *Technical Amendments and Miscellaneous Provisions Relating to Part A.*—(a) Connecticut Hospice, Inc. would receive a 2 year waiver of the inpatient day requirement provided that the proportion of the inpatient days does not exceed 50 percent and (b) Prohibits the Secretary from recouping payments to Massachusetts hospitals on or after the date of enactment and before January 1, 1988.

7. *Payments to Large Rural Hospitals Serving a Disproportionate Share of Low-Income Patients.*—Allows the Secretary, effective with discharges occurring on or after October 1, 1986, to establish a separate threshold percentage of low-income patients required for rural hospitals with 500 or more beds to qualify for disproportionate share payments.

Payment to disproportionate share hospitals would be continued for one additional year in a budget neutral fashion.

8. *Periodic Interim Payments and Prompt Payment of Claims.*—Periodic Interim Payments (PIP) would be eliminated for all PPS hospitals with exceptions. Hospitals with a disproportionate share payment add-on of 5.1 percent or more and rural hospitals with less than 100 beds that qualified for, and receive PIP payments on June 30, 1987, (under regulations in effect on October 1, 1986), would be eligible to continue to receive PIP. PIP would also be re-

tained for PPS-exempt hospitals, hospitals participating in State reimbursement systems, and certain cost-based providers (i.e., skilled nursing facilities and home health agencies). PIP would be made available to hospice providers.

Ninety-five percent of "clean" claims submitted for part A services would be required to be paid within 30 calendar days in fiscal year 1987, 26 days in fiscal year 1988, 25 days in fiscal year 1989, and 24 days in fiscal year 1990 and in subsequent years. PIP would not be eliminated for hospitals receiving such payments until the intermediary has met the prompt payment standard for 3 consecutive months. PIP would be reinstated for providers that meet the standards that were in place as of October 1, 1986, if the intermediary failed to meet prompt payment standards for 3 consecutive months.

Ninety-five percent of "clean" claims submitted for part B services would be required to be paid within 30 calendar days in fiscal year 1987, 26 days in fiscal year 1988, 25 days in fiscal year 1989, and 24 days in fiscal year 1990 and in subsequent years. "Clean" claims submitted by participating physicians would be required to be paid within 19 days in fiscal year 1988, 18 days in fiscal year 1989, and 17 days in fiscal year 1990 and in subsequent years.

9. *Health Maintenance Organization Amendments.*—Would eliminate the "two for one rule" for current nonrisk HMO medicare enrollees for months beginning April, 1987.

Would require HMOs and CMPs to provide enrollees with an explanation of enrollees' rights.

Would restrict new waivers of 50 percent medicare and medicaid enrollment requirements to HMOs in service areas where the population of medicare and medicaid beneficiaries is greater than 50 percent and to HMOs that are publicly owned and operated. Would provide new sanctions for noncompliance with the 50 percent medicare and medicaid enrollment requirement, and for noncompliance with enrollment goals for currently waivered HMOs.

Would require that HMOs pay claims submitted by physicians, suppliers and providers not under contract with the organization, within 30 calendar days of receipt in fiscal year 1987, within 26 days in fiscal year 1988, within 25 days in fiscal year 1989, and within 24 days in fiscal year 1990 and in subsequent years.

Would require that HMOs and CMPs supply, on request of the Secretary, information as to the ownership of subcontractors, and of significant business transactions between organizations and wholly owned subcontractors.

Provides that HMOs that fail substantially to provide medically necessary items and services would be subject to a penalty not to exceed $10,000 for each failure.

Would require the Secretary to provide for a study of methods by which the AAPCC and the ACR could be refined, and to submit legislative recommendations no later than January 1, 1988.

Would allow medicare beneficiaries to disenroll from an HMO or CMP at a local Social Security Office.

Provides that amounts withheld in a benefit stabilization fund during the 1986 contract year be withdrawn by the organization to the extent that payments to the organization had been reduced under the Balanced Budget and Emergency Deficit Control Act of 1985.

10. *Provisions Relating to Improvement of Quality of Care.*—Allows provider representation of beneficiaries on appeals, but would prohibit provider representation with respect to certain issues unless the provider has waived any rights for payment from the beneficiary for services involved in the appeal. Would prohibit provider representing the beneficiary from imposing any financial liability on the beneficiary in connection with representation.

Would provide beneficiaries with the right to appeal payment denials for home health services that do not meet the "intermittent or home bound" criteria.

Would prohibit a hospital from making incentive payments to a physician as an inducement to reduce services to beneficiaries, effective with payments occurring 6 months after enactment. Prohibits HMOs and CMPs from making such payments to a physician effective April 1, 1989. Requires the Secretary to study and report on incentive plans offered to physicians by HMOs and CMPs no later than January 1, 1988.

Requires the Secretary to arrange for a study to serve as the basis for establishing a strategy for reviewing and assuring quality of care under medicare.

11. *Technical Amendments and Miscellaneous Provisions Relating to Parts A and B.*—

(a) *Treatment of Group Purchasing Organizations.*—Permits the payment of administrative fees to group purchasing organizations by a vendor of the purchasing agent if the agent has an appropriate written contract and full disclosure of the payment is made of the payment to each provider.

(b) *Competitive Contracting Authority.*—Extends the authority of the Secretary to enter into competitively bid contracts with intermediaries and carriers to replace poor performing contractors for additional 3 years and clarifies language to include fixed-priced contracts.

(c) *Moratorium on HCFA Regulations.*—The Secretary would be prohibited from issuing any regulations or notices regarding hospitals or physicians before September 1, 1987, which would achieve medicare savings of more than $50 million in FY 1988.

The Secretary would be prohibited from issuing final regulations that change the methodology for computing the amount of payment for capital-related costs for inpatient hospital services under part A before September 1, 1987.

The agreement would also require the Secretary to allow 60 days for public comment on proposed regulations and notices, except for limited circumstances when such comment periods are not possible due to statutorily imposed deadlines for Secretarial action.

12. *Direct Costs of Graduate Medical Education.*—Would provide that time spent in a non-hospital outpatient setting would be counted for medicare reimbursement purposes if the hospital incurs all or substantially all of the costs of residency training in the ambulatory setting.

13. *Cost Limits for Home Health Agencies.*—Would require that limits for home health agency costs be applied on an aggregate basis for all home health services, rather than on a discipline-spe-

cific basis, effective with cost-reporting periods beginning on or after July 1, 1986.

14. *Establishment of Research Program.*—Would require the Secretary to provide for a research program on patient outcomes of selected medical treatments and surgical procedures.

15. *Civil Monetary Penalty and Exclusion Provisions.*—Would prohibit individuals who have been convicted of a Federal crime from relitigating the essential elements of the criminal offense in a subsequent civil proceeding to bar the individual from the medicare or medicaid program, or to impose civil monetary penalties. The official conducting such a hearing would have the authority to sanction a person for failing to comply with an order or procedure, failing to defend an action, or other interfering misconduct.

16. *Hospital Protocols for Organ Procurement and Standards for Organ Procurement Agencies.*—Would require, effective July 1, 1987, that no hospital may participate in medicare or medicaid unless the hospital has established protocols for encouraging organ and tissue donation. Would prohibit payment, effective January 1, 1988, under medicare and medicaid with respect to costs of procuring organs, by an organ procurement organization that does not meet the national organ transplant network standards.

17. *Medicare as Secondary Payer, Coverage Requirements of Certain other Payers.*—Medicare would be the secondary payer for disabled beneficiaries (except ESRD beneficiaries) who elect to be covered by employer-based health insurance as a current employee (or family member of such employee) of an employer with 100 or more employees. This provision would expire on January 1, 1992. Would require the Secretary to study the impact of this provision.

18. *Coverage of Services of Nurse Anesthetists.*—Extends current payment provisions for the services of hospital-employed CRNAs for cost reporting periods beginning before October 1, 1988.

Authorizes direct reimbursement for anesthesia services and related care furnished by a registered nurse anesthetist for which he/she is legally authorized to perform in the State. These payments would be made equal to the lower of 80 percent of actual charges or 80 percent of a fee schedule established by the Secretary. This provision is to be budget neutral. CRNAs would be required to accept assignment for all medicare services. The fee schedule would apply to services provided after October 1, 1988. Special limits on the actual charges of nonparticipating physicians for CRNA services and medical direction would apply.

19. *Payments for Physicians' Services.*—Provides that all physicians would receive a 3.2 percent increase in their prevailing charges effective January 1, 1987. In 1988 and in future years, prevailing charges would be increased by the percentage increase in the MEI. The Secretary would be prohibited from revising the cumulative MEI on a retrospective basis. The current differential in the prevailing charges of participating and nonparticipating physicians would be made permanent.

Would require the Secretary to conduct a study of the MEI to ensure that the index reflects economic changes in an appropriate and equitable manner. The Secretary would be precluded from changing the methodology used to determine the MEI until completion of the study.

Includes a limitation on the actual charges of nonparticipating physicians, such that over a four-year period, the actual charges of nonparticipating physicians would be capped by an amount equal to the maximum allowable actual charge (MAAC), calculated for each physician in relation to the prevailing charge. The limitation on actual charges would expire on December 31, 1990, or one year after the submission by the Secretary to the Congress of the required report on relative value scales, whichever occurs earlier.

20. *Inherent Reasonableness; Payments for Cataract Surgery.*—Would authorize the Secretary, under the inherent reasonableness authority, to establish payment levels for a physician service based on considerations other than the actual, customary, or prevailing charge for the service. Criteria and procedures for adjusting payments are specified. The Secretary would be required to review payments under this section for 10 of the most costly procedures covered under part B. If an adjustment is made on the basis of the inherent reasonableness authority that results in a payment reduction, a special limit would be applied to the actual charges of nonparticipating charges for that service.

Would specify that the prevailing charges for participating and nonparticipating physicians performing cataract surgery would be cut by 10 percent, effective January 1, 1987. An additional 2 percent reduction would be made effective January 1, 1988. In no case would the reduced allowable charge be lower than 75 percent of the national average prevailing charge. The Secretary would be required to publish, in final form, a proposed notice that would reduce payment for cataract surgery anesthesia.

Nonparticipating physicians performing cataract surgery services and cataract surgery anesthesia would be required to reduce their actual charges for these services effective January 1, 1987.

21. *End Stage Renal Disease Program.*—The Secretary would be required to reduce the composite rate payments for dialysis services by $2 for services furnished on or after October 1, 1986. The Secretary would be prohibited from revising the composite rates for two years. An application for a payment rate exception for sole facilities located in isolated rural areas would be deemed approved unless the Secretary had disapproved the application within 60 working days.

Would provide that immunosuppressive drugs furnished to a transplant patient within one year of a transplant would be covered under part B of medicare.

The Secretary would be required to establish no fewer than 17 ESRD network areas. Funding for the networks will be provided by reducing the per treatment composite rate to facilities by $.50 per treatment. The Secretary would be required to designate the network areas not later than May 1, 1987, and establish them by July 1, 1987. New networks would be required to designate the network areas not later than May 1, 1987, and establish them by July 1, 1987. New networks would be established using competitive bidding procedures under specified guidelines. The existing network organizations would remain in operation until 30 days after the new network organizations begin operations. A national end stage renal disease registry is to be established.

The Secretary would be required to establish standards and conditions of participation for safe and effective dialyzer reuse and reprocessing by medicare certified ESRD facilites to be effective October 1, 1987.

22. *Technical Amendments and Miscellaneous Provisions Relating to Part B.*—

(a) *Physician Payment Review Commission.*—Would expand the membership of the Physician Payment Review Commission by 2 members. At least one of the members would represent a rural area.

(b) *Effective Date on Voluntary Disenrollment from Medicare.*—Would modify the effective date of disenrollment from medicare when a beneficiary files a notice to disenroll to the close of the calendar quarter in which the notice was filed.

(c) *Study of Prospective Payment of Radiology, Anesthesia and Pathology Services to Hospitals Inpatient Services.*—Would require the Secretary to study and report by July 1, 1987, concerning the implementation of a part B prospective payment system for radiology, anesthesia and pathology services furnished to hospital inpatients.

23. *Vision Care.*—Would allow payment under medicare for vision care services performed by optometrists, if the services are among those already covered by medicare when furnished by a physician, and if the optometrist is authorized by state law to provide the services, effective for services furnished on or after April 1, 1987.

24. *Occupational Therapy Service.*—Would extend part B coverage of occupational therapy services to services provided in skilled nursing facilities (when part A coverage has been exhausted) in a clinic, rehabilitation agency, or public health agency, or by others in arrangements with such entities.

Would also extend part B coverage to occupational therapy services furnished by an independently practicing therapist in a therapist's office or in a beneficiary's home. Reimbursement would be provided on the basis of 80 percent of reasonable charges, with no more than $500 in incurred expenses eligible for coverage in a calendar year.

These provisions would be effective for occupational therapy services furnished on or after July 1, 1987.

25. *Coverage of Services of a Physician Assistant.*—Would authorize coverage of the services of physicians' assistants furnished under the supervision of a physician in a hospital, skilled nursing facility (SNF), intermediate care facility (ICF), or as an assistant at surgery. Physician assistant services would be reimbursed subject to a prevailing charge screen equal to 85 percent of the prevailing charge for comparable physician services performed by nonspecialists when such services are performed in a skilled nursing facility or intermediate care facility. The prevailing charge screen would be equal to 75 percent of the nonspecialist physicians prevailing charge level when such services are performed in a hospital, and 65 percent of the reasonable charge for a physician when acting as an assistant at surgery. Physician assistants would be required to accept assignment on all claims. This provision is effective with services furnished on or after January 1, 1987.

The Secretary would be required to report to Congress by April 1, 1988, concerning appropriate adjustments to payments for physician assistant services.

26. *Payment of Clinical Diagnostic Laboratory Tests.*—Would eliminate the 2-percent differential between hospital outpatient labs and independent labs (except in the case of qualified clinical labs which operate 24 hours per day), effective January 1, 1987. The January 1, 1988, sunset provision on fee schedules for such laboratory services would be eliminated. The Secretary would be required to report to Congress, not later than April 1, 1988, on the advisability, and feasibility of, and methodology for, establishing a national fee schedule for clinical diagnostic laboratory tests. Implementation of the national fee schedule would be postponed for two years, until January 1, 1990.

Would authorize the Secretary to establish a fee to cover, in certain situations, transportation and personnel expenses for trained personnel to travel to the location to collect the sample, effective January 1, 1987.

The moratorium on the competitive bidding demonstration project would be extended until January 1, 1988.

27. *Payment for Parenteral and Enteral Nutrition.*—The Secretary would be permitted to apply lowest charge level limitations to parenteral and enteral nutrition supplies. The provision would be effective for parenteral nutrients on October 1, 1987, and for all other services and supplies on January 1, 1987. The Secretary would be prohibited from using "inherent reasonableless" in establishing the lowest charge level.

28. *Changing Medicare Appeal Rights.*—Provides that beneficiaries may obtain an administrative law judge hearing if the amount in controversy is $500 or more and judicial review if the amount in controversy is over $1,000. National coverage determinations could not be overturned solely on the grounds that they were not issued in accordance with the notice and comment procedures in the Administrative Procedures Act, as amended. The court could, however, review coverage determinations to determine whether the result was arrived at in an arbitrary manner.

Regulations and policy instructions issued prior to October 1, 1979, could not be declared invalid. In the case of policies which are invalidated by the court, the Secretary could not be required to reopen and reprocess claims previously resolved, except with respect to the litigants. The Secretary could be required to implement a new policy prospectively.

29. *Alzheimer's Disease Demonstration Projects.*—Would require the Secretary to conduct up to 10 demonstration projects to determine the effectiveness, cost and impact of providing comprehensive services to Medicare beneficiaries who have Alzheimer's disease or related disorders. Total expenditures cannot exceed $40 million over three years.

30. *Ambulatory Surgery.*—Effective for cost reporting periods beginning on or after October 1, 1987, a new payment methodology would apply for facility services provided by hospital outpatient departments (OPDs) in connection with ambulatory surgery procedures. Payment would be based on a blend of the amount that would be paid to a hospital under cost reimbursement and the

amount that would be paid to a freestanding ambulatory surgery center (ASC) for the same service. During the first cost reporting year the blend would be 75 percent cost and 25 percent ASC rate; during the second cost year and subsequently, the blend would be 50 percent cost and 50 percent ASC rate. A 20 percent coinsurance would apply to services provided by hospital OPDs and ASCs in connection with ambulatory surgery. The Secretary would be required to submit a final report concerning development of a prospective payment methodology for ambulatory surgery services by April 1, 1989.

31. *Peer Review Organizations.*—Procedures for appeal of hospital denials of continued inpatient stay would be modified to ensure that a beneficiary who makes an appeal is not liable for continued stay until noon on the day after receiving notice of the PRO's decision. PRO review of early readmission cases would be expanded. The requirement that PROs review services provided by HMOs and CMPs would be delayed from January 1 to April 1, 1987. In up to 25 States containing up to 50 percent of the medicare beneficiaries enrolled in HMOs or CMPs, the Secretary could provide for a State-by-State competition for review of HMO and CMP services. The current PRO in those States could compete for these contracts as could other entities provided that such entities satisfy requirements contained in sections 1152 and 1153(b) of the Social Security Act. In the remaining 25 States, review must be conducted by the PROs for those States. A consumer representative would be required on each PRO governing board. PROs would be required to review beneficiary complaints concerning quality. PROs would be required to share certain confidential information with State licensure agencies and with national accreditation bodies.

32. *Continuation Coverage for Retirees in Cases of Bankruptcies.*—Beginning on or after July 1, 1986, any retiree and dependents, who lose their employer-based health insurance coverage because their employer filed for Chapter 11 bankruptcy, would be entitled to remain in the employer health insurance plan if the retiree pays up to 102 percent of the applicable premium. The retiree, the widow of the retiree, and the spouse and dependent children of the retiree may remain in the health plan until the death of the retiree. Upon the death of the retiree the surviving spouse and the dependent children may remain in the group health plan for up to 3 years.

REPORTS AND STUDIES

The following is a list of studies and reports required by law which are either past due or to be concluded in the next 3 years.

Topic	Due date
Secretary of HHS to report with legislative recommendations on demonstration project to determine (1) the extent to which the commencement of nutritional therapy in early renal failure can retard or arrest the progression of the disease and the administrative, financial, and other aspects of making such nutritional therapy generally available under medicare. (Section 958(h), Public Law 96–499).	December 5, 1982.

Topic	Due date
Secretary of HHS to report with legislative recommendations on demonstration project to determine the administrative, financial, and other aspects of making the services of clinical social workers more generally available as part of the benefits received under medicare. (Section 958(h), Public Law 96–499).	December 5, 1982.
Secretary of HHS to conduct and promptly complete all studies and experiments required under present law which pertain to the use of, and reimbursement for, nutritional therapy; and that the Secretary transmit a full and complete report with respect to each study and experiment. (Public Law 97–35).	January 1, 1983.
Secretary of Health and Human Services shall report to the Committee on Ways and Means and the Committee on Finance on proposals developed for prospective reimbursement of skilled nursing facilities under medicare (as required under sec. 1135(c) of the Social Security Act. (Sec. 2319(f)(1), Public Law 98–369; H.R. 4170).	August 1, 1984.
Secretary of Health and Human Services shall conduct a study and report to the Congress on higher medicare payment rates for sole community hospitals as a result of needed expansion of services at such hospitals. (Sec. 9111(c), Public Law 99–272; H.R. 3128).	December 31, 1986.
The Secretary of HHS is directed to report on the advisability and feasibility of a system of direct payment to any physicians for all clinical diagnostic lab tests ordered by such physicians. (Section 2303(i) (2) and (3), Public Law 99–369).	January 1, 1987.
The Congressional Budget Office shall study and report to Congress on the impact of the implementation of section 9105 of P.L. 99–272 on hospitals with respect to payments for hospitals which serve a disproportionate share of low-income patients. (Section 9105(d)), Public Law 99–272.	January 1, 1987.
Secretary of HHS shall conduct a study on the effects of the amendment made by section 9111(a) relating to payments to sole community hospitals. The report shall include recommendations for a permanent mechanism to take into account needed expansions of services by sole community hospitals and the hospital-specific medicare payments thereof. (Section 9111(c)), Public Law 99–272.	January 1, 1987
Secretary of HHS shall review and report to Congress on the impact of policies respecting outliers and patient transfers on payments made under section 1886(d) of the Act to rural hospitals, particularly on rural hospitals with less than 100 beds. (Section 9113(a)), Public Law 99–272.	January 1, 1987.
Comptroller General shall report to the Congress on the appropriateness of fee schedules under sec. 1833(h) of the Social Security Act—clinical diagnostic laboratory tests—their impact on the volume and quality of such tests. (Sec. 2303(i) (1) and (3), Public Law 98-369; H.R. 4170).	January 1, 1987.
Secretary of Health and Human Services after consultation with the Physician Payment Review Commission, shall develop recommendations and guidelines, and report to the Congress, respecting surgical procedures for which an assistant at surgery is generally not medically necessary and the circumstances under which the use of an assistant at surgery is generally appropriate but should be subject to prior approval of an appropriate entity. (Sec. 9307(d), Public Law 99–272; H.R. 3128).	January 1, 1987.
Secretary of HHS shall report to Congress on the frequency and distribution of denials of bills for payment for extended care services, home health services, and hospice care, because care was not reasonable and necessary or was custodial, and other information needed to evaluate the appropriateness of denial rates established for a favorable presumption. (Section 9305(g)(2)), Public Law 99–509.	March 31, 1987.
Secretary of HHS shall report to Congress on the standards that might be established under the medicare program for clinical laboratories which are part of or associated with a physician's office to assure the health and safety of individuals with respect to whom the laboratories perform clinical diagnostic laboratory tests for which payment may be made under the program. (Section 9303(C)), Public Law 99–272.	April 7, 1987.
National Center for Health Services Research and Health Care Technology shall conduct a study and report to the House Committees on Ways and Means, Energy and Commerce, and Appropriations and the Senate Committees on Finance, and Appropriations with respect to the findings of the patient outcome assessment research program. (Sec. 9316(a), Public Law 99–509; H.R. 5300).	April 21, 1987.

Topic	Due date
Secretary of HHS shall report to Congress on the development of a relative value scale for physician services that establishes a numerical relationship among the various physicians' services for which medicare and medicaid payments are made. (Section 9305(b)), Public Law 99-272.	July 1, 1987.
Secretary of HHS shall conduct a study and report to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives with respect to approved educational activities relating to nursing and other health professions for which reimbursement is made to hospitals under medicare. (Section 9202(c)(1)), Public Law 99-272.	December 31, 1987.
The Comptroller General shall conduct a study of the variation in the amounts of payments made under title XVIII of the Act with respect to patients in different teaching hospital settings and in the amounts of such payments which are made with respect to patients who are treated in teaching and nonteaching hospital settings. (Section 9202(d)), Public Law 99-272.	December 31, 1987.
Secretary of HHS shall report to Committee on Finance of the Senate and Committees on Ways and Means and Energy and Commerce of the House of Representatives on whether section 1886(h) of the Act should be revised to provide greater uniformity in the approved FTE resident amounts established under paragraph 2 of the Act. (Section 9202(e)), Public Law 99-272.	December 31, 1987.
Secretary of HHS shall study and report to the Committee on Finance of the Senate and Committees on Ways and Means and Energy and Commerce of the House of Representatives with respect to the use of physicians who are foreign medical graduates in the provision of health care services to medicare beneficiaries. (Section 9202(f)).	December 31, 1987.
Secretary of HHS shall provide for a study to evaluate the effects of reductions in the rates of payment for facility and physician services' under the medicare program for patients with end stage renal disease on their access to care or on the quality of care. (Section 9335(b)), Public Law 99-509.	January 1, 1988.
Secretary of HHS shall submit to Congress a legislative proposal concerning methods by which the average adjusted per capita cost (AAPCC) and adjusted community rate (ACR) can be refined to more accurately reflect the cost of providing care to different classes of patients. (Section 9312(g)), Public Law 99-509.	January 1, 1988.
Secretary of HHS shall report to Congress on the types of physician arrangement plans commonly in use by HMOs and CMPs, and evaluate their potential to limit or reduce medical services, and make recommendations regarding appropriate plans which may encourage efficiency in utilization of services without posing a potential for an adverse effect on quality. (Section 9313(c)(3)), Public Law 99-509.	January 1, 1988.
Secretary of HHS is directed to report to Congress with respect to the use of stabilization funds by eligible organizations under section 1876(g)(5) of the Act and shall assess the need for such funds. (Section 2350(b)(4)), Public Law 98-369.	January 18, 1988.
Secretary of Health and Human Services shall submit a final report to the Congress on social health maintenance organization projects. (Sec. 2355(d)(2), Public Law 98-369; H.R. 4170).	January 18, 1988.
The Comptroller General shall study and report to Congress on the appropriateness and impact on medicare beneficiaries of applying per visit home health agency cost limits on a discipline-specific basis, rather than on an aggregate basis; and the appropriateness of the percentage established in regulation. (Section 9315(c)), Public Law 99-509.	February 1, 1988.
The Prospective Payment Assessment Commission to report to Congress on the feasibility, impact, and desirability of eliminating or phasing out separate urban and rural DRG prospective payment rates. (Public Law 100-203; H.R. 3545).	March 1, 1988.
Secretary of Health and Human Services shall conduct a study and report to Congress information on the frequency and distribution (by type of provider) of denials of bills for payment under title XVIII of the Social Security Act for extended care services, home health services, and hospice care. (Sec. 9305(g)(2), Public Law 99-509; H.R. 5300).	March 31, 1988.

Topic	Due date
Secretary shall report to Congress concerning adjustments to the amount of payment made, under medicare part B, for services described in section 1861(s)(2)(K) of the Act to ensure that the amount reflects the approximate cos of furnishing the services, taking into account compensation costs and overhead and supervision costs attributable to physician assistants. (Section 9338(e)), Public Law 99-509; H.R. 5300).	April 1, 1988.
Secretary of HHS shall report to Congress on the advisability and feasibility of, and methodology for, establishing national fees schedule for payment for clinical diagnostic laboratory tests under section 1833(h) of the Act. (Section 9339(b)(3)), Public Law 99-509..	April 1, 1988.
Secretary of HHS shall submit an interim and final report on the development of a prospective payment methodology for outpatient hospital services. (Section 9343(f)), Public Law 99-509.	April 1, 1988, April 1, 1989.
The Prospective Payment Assessment Commission shall study and report to the House Committee on Ways and Means and the Senate Committee on Finance on the suitability and feasibility of linking payment for capital-related costs under part A of title XVIII of the Social Security Act to hospital occupancy rates. (Public Law 100-203; H.R. 3545).	May 1, 1988.
Secretary of Health and Human Services shall conduct a study and report to Congress of variations in payment practices for physicians' services among the different carriers under sec. 1842 of the Social Security Act. (Public Law 100-203; H.R. 3545).	May 1, 1988.
Secretary of Health and Human Services shall conduct a study and submit an interim report to Congress on the volume and intensity of physicians' services under part 8 of title XVIII of the Social Security Act. (Public Law 100-203; H.R. 3545).	May 1, 1988.
Secretary of Health and Human Services shall study and report to Cogress on (1) whether the separate schedules of cost limits currently applied to home health agencies located in urban and rural areas accurately reflect differences in the costs of urban and rural home health agencies; and (2) the appropriateness of modifying such limits to take into account the proportion of agency patients who are from urban and rural areas. (Public Law 100-203; H. R. 3545).	June 1, 1988.
General Accounting Office shall conduct a study and report to the Congress on (1) the appropriateness and impact on medicare beneficiaries of applying the per visit cost limits for home health services under sec. 1861(v)(1)(L) of the Social Security Act on a discipline-specific basis, rather than on an aggregate basis, for all home health services furnished by an agency, and (2) the appropriateness of the percentage limits established under such section. (Sec. 9315(c), Public Law 99-509; H.R. 5300.) (Jan. 20, 1988. Letter from Chairman to GAO granting extension of time to June 30, 1988).	June 30, 1988.
Secretary of HHS shall study and report to Congress on the adequacy of the standards used for hospitals, for purposes of meeting the conditions of participation, in assuring the quality of services furnished in hospitals. (Section 9305(d)), Public Law 509.	October 21, 1988.
Secretary of HHS shall report to Congress on a legislative proposal to improve the classification and payment system under section 1886(d) of the Social Security Act (and, as appropriate, the system for payment of outliers) in order to assure that the amount per discharge approximates the cost of medically necessary care provided in an efficient manner for individual patients or classes of patients with similar conditions. This proposal shall account for variations in severity of illness and cases complexity. (Section 9305(a)), Public Law 99-509.	October 21, 1988.
Secretary of HHS shall report to Congress its findings of a study to develop a strategy for quality review and assurance under the medicare program. (Section 9313(d)), Public Law 99-509.	October 21, 1988.
Secretary of HHS shall report to Congress on the development of a uniform needs assessment instrument(s) that evaluates the functional capacity of a beneficiary, and requirements to meet health care needs which can be used by discharge planner, health care providers and intermediaries in evaluating the beneficiary's need for post-hospital health care or services. (Section 9305(h)), Public Law 99-509.	January 1, 1989.
Secretary of HHS shall report to Congress on a study to determine whether a payment should be made (in a budget neutral fashion) to hospitals for administratively necessary days, separate from the per-discharge and outlier payments. (Section 9305(e)), Public Law 99-509.	January 1, 1989.

Topic	Due date
The Prospective Payment Assessment Commission shall report to Congress on the desirability of maintaining separate DRG prospective payment rates for hospitals located in large urban areas and in other urban areas. (Public Law 100–203; H.R. 3545).	January 1, 1989.
The General Accounting Office shall conduct a study and submit an interim report to the House Committees on Ways and Means, and Energy and Commerce, and the Senate Finance Committee on medicare capitation. (Public Law 100–203; H.R. 3545).	January 1, 1989.
The General Accounting Office shall conduct a study and report to Congress on payment for physician anesthesia services. (Public Law 100–203; H.R. 3545).	January 1, 1989.
Secretary of Health and Human Services shall provide for a demonstration project to develop and test alternative methods of paying home health agencies on a prospective basis for services furnished under the medicare and medicaid programs, and submit an interim report to Congress. (Public Law 100–203; H.R. 3545).	January 5, 1989.
Secretary of Health and Human Services shall report to Congress on improvements in procedures for imposing sanctions against a practitioner or person established through agreement by the Health Care Financing Administration, the American Association of Retired Persons, the American Medical Association, and the Office of the Inspector General in the Department of Health and Human Services. (Public Law 100–203; H.R. 3545).	January 5, 1989.
Secretary of Health and Human Services shall report to Congress with respect to stabilization funds by eligible organizations under sec. 1876(g)(5)—health maintenance organizations—of the Social Security Act, assessing the need for such funds. (Sec. 2350(b)(4), Public Law 98–369; H.R. 4170).	January 18, 1989.
Secretary of HHS shall report to Congress of its findings from a demonstration project concerning prior and concurrent authorization for post-hospital extended care services and home health services furnished under medicare part A and part B. (Section 9305(k)), Public Law 99–509.	February 1, 1989.
Secretary of Health and Human Services shall report to Congress concerning (1) the proportion of admissions to hospitals for extended care services which are denied or approved by a peer review organization; and (2) on recommendations for methods of encouraging hospitals that (a) have a low occupancy rate, (b) are eligible to enter (but have not entered) into an agreement, and (c) are located in areas with a need for additional providers of extended care services, to enter into such agreements. (Public Law 100–203; H.R. 3545).	February 1, 1989.
Secretary of Health and Human Services shall report to Congress on the criteria used for the classification of hospitals as rural referral centers. (Public Law 100–203; H.R. 3545).	March 1, 1989.
Secretary of Health and Human Services shall report to Congress on the adequacy of the amounts paid for rural health clinic services provided by independent rural health clinics. (Public Law 100–203; H.R. 3545).	March 1, 1989.
Secretary of Health and Human Services shall submit to the Congress a final report on the development of a fully prospective payment system for ambulatory surgical procedures performed on patients in hospitals on an outpatient basis. (Sec. 9343(f), Public Law 99–509; H.R. 5300).	April 1, 1989.
Secretary of Health and Human Services shall report to the House Committees on Ways and Means and Energy and Commerce, and the Senate Committee on Finance on the relative value scale, fee schedules, and the index developed under this section. (Public Law 100–203; H.R. 3545).	April 1, 1989.
Secretary of Health and Human Services to study and report to Congress on payment for chemotherapy in physicians' offices (Public Law 100–203; H.R. 3545).	April 1, 1989.
Secretary of HHS shall report to the Committee on Finance of the Senate and Committees on Ways and Means and Energy and Commerce of the House of Representatives on the progress made in the demonstration program, required by section 9314 of P.L. 99–272, including a description of the sites at which the program is being conducted and the preventive health services begin provided at the different sites. (Section 9314(e)(1)), Public Law 99–272.	April 7, 1989.
Secretary of HHS shall report to Congress on the results of the amendments made by section 1164 of the Act relating to 100 percent peer review of certain surgical procedures. (Section 9401(e)), Public Law 99–272.	April 7, 1989.

Topic	Due date
Secretary of Health and Human Services shall submit a final report to Congress of issues relating to the volume and intensity of physicians' services. (Public Law 100–203; H.R. 3545).	May 1, 1989.
The General Accounting Office shall conduct a study and report to Congress concerning the cost effectiveness of requiring hearings with a carrier before having a hearing before an administrative law judge. (Public Law 100–203; H.R. 3545).	June 30, 1989
Secretary of Health and Human Services shall report to the Congress on the development of a relative value scale for physicians' services. (Sec. 9305(b), Public Law 99–272; H.R. 3128).	July 1, 1989.
Secretary of Health and Human Services shall conduct a study and report to Congress of changes in the payment system for physicians' services that would be required for the implementation of a national fee schedule for such services furnished on or after Jan. 1, 1990. (Public Law 100–203; H.R. 3545).	July 1, 1989.
The Prospective Payment Assessment Commission shall perform an analysis and report to Congress on the feasibility and appropriateness of adjusting the non-wage-related portion of the adjusted average standardized amounts based on area differences in hospitals' costs (other than wage-related costs) and input prices. (Public Law 100–203; H.R. 3545).	October 1, 1989.
The General Accounting Office shall conduct a study and submit an interim report to the House Committees on Ways and Means, and Energy and Commerce, and the Senate Committee on Finance on medicare capitation. (Public Law 100–203; H.R. 3545).	January 1, 1990.
Secretary of Health and Human Services shall conduct a study and report to the Congress on incentive payments for physicians' services furnished in underserved areas (Public Law 100–203; H.R. 3545).	January 1, 1990.
The General Accounting Office shall conduct a study and report to Congress on the level of the fee schedules established for clinical diagnostic laboratory services to determine, based on the costs of, and revenues received for, such tests the appropriateness of such schedules. (Public Law 100–203; H.R. 3545).	January 1, 1990.
The Comptroller General shall study and report to Congress on the impact of the amendments made by section 9319 of P.L. 99–509 (relating to medicare as secondary payor for disabled employees of certain large employers) on access of disabled individuals and members of their family to employment and health insurance. (Section 5000(e)), Public Law 99–509.	March 1, 1990.
The General Accounting Office shall conduct a study and report to Congress on payment for physician anesthesia services. (Public Law 100–203; H.R. 3545).	April 1, 1990.
Secretary of HHS shall conduct a study and report to the Committee on Finance of the Senate and the Committees on Ways and Means and the Energy and Commerce of House of Representatives with respect to the advisability of continuing or terminating the exception under section 1886(h)(5)(F)(ii) of the Act for geriatric residencies and fellowships, and of expanding such exception to cover other eductional activities. (Section 9202(c)(2)), Public Law 99–272.	July 1, 1990.
Secretary of Health and Human Services shall conduct a survey and report to Congress on out-of-pocket costs of medicare beneficiaries for health care services. Public Law 10–203; H.R. 3545).	July 1, 1990.
Secretary of Health and Human Services shall conduct a demonstration project and report to Congress on payment for therapeutic shoes for individuals with severe diabetic foot disease. (Public Law 100–203; H.R. 3545).	October 1, 1990.
The General Accounting Office shall conduct a study and submit a final report to Congress on medicare capitation. (Public Law 100–203; H.R. 3545).	January 1, 1991.
Secretary of Health and Human Services shall conduct a standard and extended survey on home health agencies and report to Congress on the results of such evaluation. (Public Law 100–203; H.R. 3545).	January 1, 1991.
Secretary of Health and Human Services shall conduct a study and evaluation and report to Congress on amendments made to this section on the availability of covered items and shall evaluate the appropriateness of the volume adjustment for oxygen and oxygen equipment. (Public Law 100–203; H.R. 3545).	January 1, 1991.
Secretary of Health and Human Services shall study and report to Congress on the End-State Renal Disease program. (Public Law 100–203; H.R. 3545).	January 5, 1991.
Secretary of HHS shall submit to the same committees mentioned above a final report on the demonstration program required by section 9314 of P.L. 299–272. (Section 9314(e)(2)).	April 7, 1991.

Topic	Due date
Secretary of Health and Human Services shall conduct a demonstration project and report to Congress on providing payment on a prepaid, capitated basis for community nursing and ambulatory care furnished to medicare beneficiaries. (Public Law 100–203; H.R. 3545).	January 1, 1992.
Secretary of Health and Human Services shall conduct a study and report to Congress on the implementation of the resident assessment process for residents of skilled nursing facilities. (Public Law 100–203; H.R. 3545).	January 1, 1992.
Secretary of HHS shall report to Congress on a rural secondary specialty demonstration project which is to determine the effect that a modified system of making payments under part A to such centers would have on total expenditures under such part and the access of medicare beneficiaries located in rural areas to quality health care. (Section 9302(d)(4)), Public Law 99–509.	No date certain.
Secretary of HHS shall study and report to Congress of the extent to which the medicare economic index (MEI) appropriately and equitably reflects the changes in the provision of the physicians' services to medicare beneficiaries (Section 9331(c)(4)), Public Law 99–509.	No date certain.
Secretary of HHS shall conduct a study and report to Congress on the advisability of redefining the localities designated by carriers for payment purposes. (Section 9331(e)(1)), Public Law 99–509.	No date certain.
Secretary shall provide for an evaluation of the demonstration projects and shall submit to the Committees on Energy and Commerce and Ways and Means of the U.S. House of Representatives and the Committee on Finance of the Senate a preliminary report during the third year of the Alzheimer's Disease Demonstration Projects, required under section 9342(a) of P.L. 99–509, and a final report upon completion of the projects, which shall include legislative recommendations. (Section 9342(d)), Public Law 99–509.	No date certain.
Secretary of HHS shall submit a final report to Congress on a study evaluating the extent of, and reasons for, the termination by medicare beneficiaries of their memberships in organizations with contracts under section 1876 of the Act placing special emphasis on the quantity and quality of such medical care provided in such organizations and the quality of such care when provided on a fee-for-service basis. (Section 114(e), Public Law 97–248).	Within 5 years after implementation.
Secretary of HHS shall report on adjustments that may be required in medicare prospective payment amounts for such cases which have an unusually short length of stay or which are significantly less costly than the DRG payment with recommendations on how to address this issue. (Public Law 98–21).	No date certain.
Secretary of HHS shall report on the advisability of continuing a fee schedule for hospital-based lab servicing hospital outpatients, and if advisable, the appropriate fee level. (H. Rpt. 98–861, p. 1305, Public Law 98–369).	No date certain.
Secretary of Health and Human Services shall review the report of the Director of the Office of Technology Assessment, due to be submitted to Congress by Dec. 31, 1985, on medicare part B payments to physicians. (Sec. 2309(c), Public Law 98–369; H.R. 4170).	No date certain.

APPENDIX B. HEALTH STATUS, HEALTH INSURANCE, AND HEALTH CARE EXPENDITURES OF THE ELDERLY

Although the health status of the elderly appears to have been improving in recent decades, many of the elderly have conditions that require health care, sometimes in substantial amounts. Nearly all of the elderly have some insurance that protects them, at least partially, from the expenses arising from health care use. Many are well insured for their acute care needs—that is, for hospital and physician services. Others face greater risk of high out-of-pocket expenditures. This appendix reports on the health status, health insurance, and health care expenditures of the elderly.

HEALTH STATUS

By various measures, the health status of the elderly population has been improving over the years. For example, life expectancy at age 65 has increased from 13.9 years in 1950 to 16.8 years in 1984 (see table 1). The improvements in life expectancy—or, alternatively, the declines in mortality rates—have been greater for females than for males. Morbidty indicators—such as the incidence of high blood pressure—also improved among those aged 65 to 74 years between the early 1960's and the late 1970's (see table 2).

TABLE 1.—LIFE EXPECTANCY AT BIRTH AND AT 65 YEARS OF AGE, BY SEX, UNITED STATES, SELECTED YEARS 1900–84

Year	At birth			At 65 years		
	Both sexes	Male	Female	Both sexes	Male	Female
	Remaining Life Expectancy in Years					
1900 [1, 2]	47.3	46.3	48.3	11.9	11.5	12.2
1950 [2]	68.2	65.6	71.1	13.9	12.8	15.0
1960 [2]	69.7	66.6	73.1	14.3	12.8	15.8
1970	70.9	67.1	74.8	15.2	13.1	17.0
1980	73.7	70.0	77.4	16.4	14.1	18.3
1984 [2, 3]	74.7	71.7	78.3	16.8	14.5	18.7

[1] Death registration area only; includes 10 States and the District of Columbia.

[2] Includes deaths of nonresidents of the United States.

[3] Provisional data.

Source: National Center for Health Statistics, Health, United States, 1985, DHHS Pub. No. (PHS) 86–1232, p. 40.

TABLE 2.—SELECTED HEALTH STATUS INDICATORS FOR PERSONS 65–74 YEARS OF AGE, BY SEX, 1960–62, 1971–74, AND 1976–80

Health status indicator	Both sexes			Male			Female		
	1960–62	1971–74	1976–80	1960–62	1971–74	1976–80	1960–62	1971–74	1976–80
	Percent of Population								
Borderline or definite elevated blood pressure [1]	73.8	70.3	63.1	65.9	65.4	62.0	80.3	74.1	63.9
Definite elevated blood pressure [2]	48.7	40.9	34.5	40.5	36.4	33.3	55.4	44.4	35.5
High-risk serum cholesterol levels [3]	37.3	31.3	27.2	20.8	19.9	18.1	50.8	40.0	34.3
Overweight [4]	34.6	31.5	32.7	23.8	23.0	25.2	43.3	38.0	38.5

[1] Borderline or definite elevated blood pressure is defined as either systolic pressure of at least 140 mmHg or diastolic pressure of at least 90 mmHg or both based on a single measurement.

[2] Definite elevated blood pressure is defined as either systolic pressure of at least 160 mmHg or diastolic pressure of at least 95 mmHg or both based on a single measurement.

[3] High-risk serum cholesterol levels are defined by age-specific cut points of the cholesterol distribution. For 40 years of age and over, high risk is greater than 260 milligrams/deciliter. Risk levels defined by NIH Consensus Development conference statement on lowering blood cholesterol, December 10, 1984.

[4] Overweight is defined for men as body mass index greater than or equal to 27.8 kilograms/meter ^{2}, and for women as body mass index greater than or equal to 27.3 milograms/meter ^{2}. These cut points were used because they represent the sex-specific 85th percentiles for persons 20–29 years of age in the 1976–80 National Health and Nutrition Examination Survey.

Source: National Center for Health Statistics, Health, United States, 1985, DHHS Pub. No. (PHS) 86–1232, pp. 76–79. Data are based on physical examinations of a sample of the civilian, noninstitutionalized population.

Despite the trend toward generally improved health status of the elderly, their needs for health care remain substantial. First, greater life expectancy merely postpones the inevitable need for terminal illness care. (About two-thirds of the deaths in the United States are of the elderly. A recent study found that the 6 percent of Medicare beneficiaries who died in 1978 accounted for 28 percent of Medicare expenditures.[1]) Second, many of the elderly have one or more chronic conditions, many of which give rise to the need for continuing health care. Table 3 shows the incidence of several common chronic conditions among the elderly. Nearly half report having arthritis, about 40 percent report high blood pressure, and over one-fourth report heart disease. The incidence of many chronic conditions is directly related to age and inversely related to family income.

Another common measure of health status is self-assessment, on a scale ranging from "excellent" to "poor." Over one-third of the elderly report their health to be excellent or very good, but nearly another third report fair or poor health (see table 4). Lower-income elderly are more likely to report fair or poor health—over 40 percent of those with incomes under $10,000, compared to under 30 percent at incomes above this level.

TABLE 3.—NUMBER OF SELECTED CHRONIC CONDITIONS PER 1,000 ELDERLY PERSONS, BY AGE AND FAMILY INCOME, 1986

Type of chronic condition	All elderly	Age		Family income [1]		
		65–74	75 and over	Less than $10,000	$10,000 to $19,999	$20,000 to $34,999
Arthritis	480	443	540	568	459	355
Cataracts	141	84	233	192	157	93
Hearing impairment	296	244	378	337	308	293
Deformity or orthopedic impairment	173	158	196	215	174	122
Hernia of abdominal cavity	61	47	85	89	50	43
Diabetes	98	92	109	109	96	95
Heart disease	277	250	319	358	254	295
High blood pressure (hypertension)	394	385	409	477	396	366
Emphysema	40	45	33	45	36	52

[1] Too few elderly at incomes of $35,000 and above were surveyed to provide reliable estimates for most conditions.

Source: National Center for Health Statistics, Current Estimates from the National Health Interview Survey, United States, 1986, Vital and Health Statistics, Series 10, No. 164, pp. 85, 86, 91–94. Data are based on household interviews of the civilian, noninstitutionalized population.

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[1] J. Lubitz and R. Prihoda, "The Use and Costs of Medicare Services in the Last Two Years of Life," Health Care Financing Review, Volume 5, 1984, pp. 117–131.

TABLE 4.—NUMBER OF ELDERLY PERSONS AND PERCENT DISTRIBUTION BY RESPONDENT-ASSESSED HEALTH STATUS, BY SEX AND FAMILY INCOME, 1986

Characteristic	All persons [1] (in thousands)	Respondent-assessed health status [2]					
		All health status [3]	Excellent	Very good	Good	Fair	Poor
All elderly [4]	27,538	100.0	16.4	20.8	32.9	20.1	9.8
Sex:							
Male	11,357	100.0	17.0	21.4	32.4	19.5	9.7
Female	16,181	100.0	16.0	20.4	33.3	20.5	9.9
Family income:							
Under $10,000	7,154	100.0	11.2	16.7	30.4	27.0	14.6
$10,000 to $19,999	7,587	100.0	15.2	20.9	35.2	19.6	9.1
$20,000 to $34,999	5,027	100.0	23.2	24.5	32.1	14.9	5.2
$35,000 and over	2,642	100.0	25.6	23.8	33.0	11.7	5.9

[1] Includes unknown health status.

[2] The categories related to this concept result from asking the respondent, "Would you say — health is excellent, very good, good, fair, or poor?" As such, it is based on the respondent's opinion and not directly on any clinical evidence.

[3] Excludes unknown health status.

[4] Includes unknown family income.

Source: National Center for Health Statistics, Current Estimates from the National Health Interview Survey, United States, 1986, Vital and Health Statistics, Series 10, No. 164, pp. 115, 116. Data are based on household interviews of the civilian, noninstitutionalized population.

HEALTH INSURANCE

Nearly all of the elderly (99 percent) are covered for some medical expenses under at least one type of health insurance, with over 96 percent of them covered under Medicare. Because of the remaining out-of-pocket liabilities for Medicare's covered services (for example, deductibles and coinsurance) and the fact that some health care services are not covered by Medicare, over 20 million, or 80 percent, of the elderly have additional coverage through private supplementary insurance or Medicaid.[2]

As figure 1 shows, in 1984, 18 million—or 72 percent—of the elderly were covered by some form of private supplementary insurance, either as part of a group (generally insured through their current or former employer or union) or under an individual policy. There is considerable variation in the benefits offered under these policies, ranging from the conventional employer-provided insurance held by the working aged to hospital indemnity plans that pay only a limited sum for each day of hospitalization.[3]

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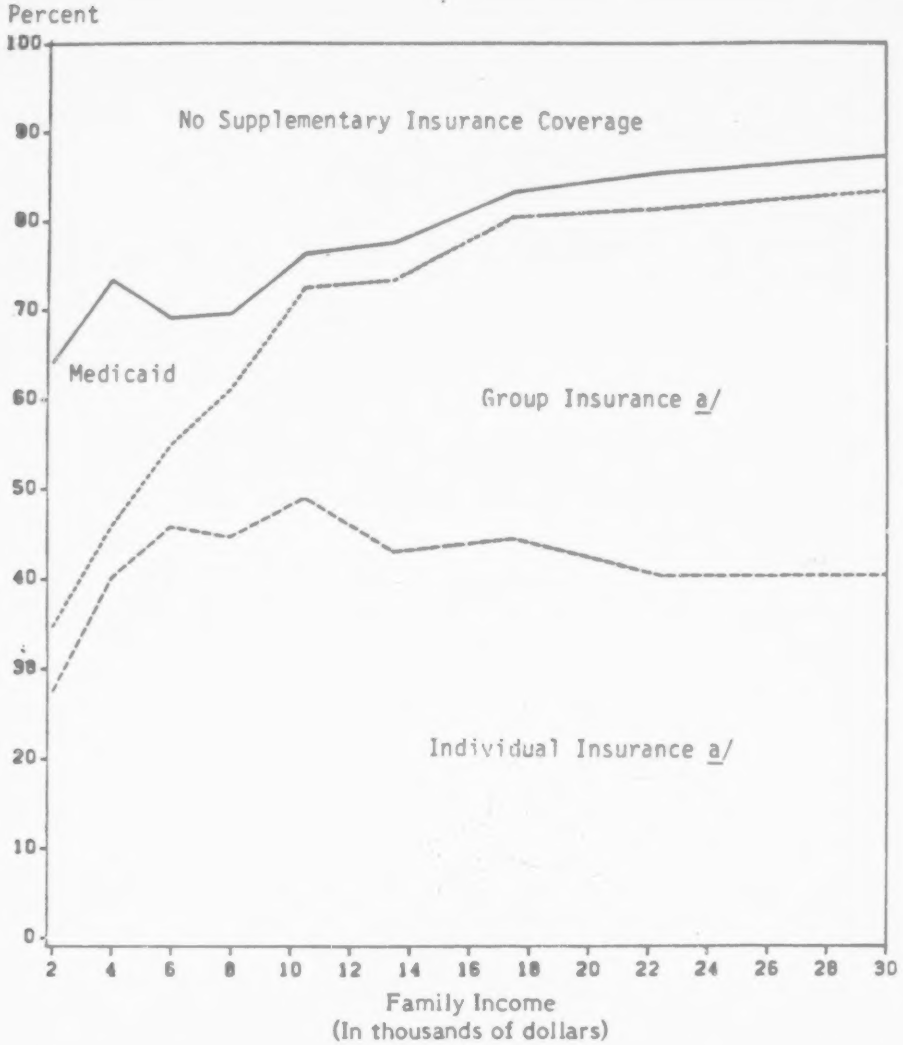
[2] Most of the estimates in this section are based on the April 1984 Survey of Income and Program Participation (SIPP), which covers the civilian, noninstitutional population of the United States. Therefore, about one million institutionalized elderly, many covered by Medicaid, are excluded from this discussion of supplementary insurance. Individuals who have both private policies and Medicaid eligibility are included in the Medicaid category.

[3] The situation differs for those elderly under age 70 who are employed and covered by their employers' health plan, and for spouses under 70 who are covered by plans of workers under age 70. These private insurance plans must pay all bills that they cover, with Medicare serving as a secondary payer. Little is known about these beneficiaries or the characteristics of these plans.

FIGURE 1. PERCENT OF ELDERLY MEDICARE ENROLLEES HAVING SUPPLEMENTARY INSURANCE COVERAGE, BY FAMILY INCOME, APRIL 1984



SOURCE: Congressional Budget Office tabulations of Survey of Income and Program Participation (SIPP).

a. The SIPP questionnaire allows for description of only one type of private insurance plan. The first descriptive question asks whether it was an employer or union plan. Therefore, people who were covered under both a group and an individual plan are likely to have been classified above as covered by group insurance.

The most common form is the "medigap" policy, which is designed to pay part or all of Medicare's deductible amounts and coinsurance. In all but one State, these policies are required to meet minimum standards at least as stringent as those set out under the Baucus amendment to the 1980 Social Security Disability Act (Public Law 96-265). These standards require coverage of nearly all SMI coinsurance, all HI coinsurance, and 90 percent of all hospital expenses for 365 days beyond exhaustion of HI's coverage. Consequently, medigap policies greatly reduce the risks of high out-of-pocket expenditures associated with Medicare's covered services, although most policies do not cover other costs such as those for prescription drugs.

To obtain medigap coverage, of course, the elderly (or an employer or union) must pay a premium reflecting the generosity of the benefit package, as well as administrative and marketing costs that ranged from 15 percent to 35 percent of the premium. Annual medigap premiums averaged roughly $300 to $400 per person in 1984, though as a result of considerable differences in benefits and administrative costs, they ranged from as low as $150 to over $1,000.

The likelihood of an elderly person having private insurance rises with family income. As figure 1 also shows, 44 percent of those with incomes under $5,000 were covered, compared with 87 percent of those with incomes of $25,000 or more. Group insurance was more likely among those who had higher incomes, were younger, lived with their spouses, or were employed, while ownership of individual policies was more evenly distributed.

An additional 2 million, or 8 percent, of the elderly were eligible for Medicaid in April 1984. Medicaid eligibility, which is closely linked to receipt of SSI cash benefits, is largely concentrated among those with low incomes. In the 38 States with programs for the "medically needy," some elderly with incomes above cash assistance standards may also become eligible for Medicaid, especially if they have incurred high out-of-pocket expenses relative to their incomes.

Once covered by Medicaid, an elderly person faces little risk of high out-of-pocket expenses—the SMI premium and Medicare's cost sharing requirements are generally paid by Medicaid. Moreover, physicians who treat Medicaid patients may not bill these patients for any charges not paid by Medicare or Medicaid. Finally, many States cover a wide range of additional services as optional benefits that further reduce the risks to these elderly—48 of 50 Medicaid programs covered prescription drugs in 1981, for example.

TABLE 5.—CHARACTERISTICS OF ELDERLY MEDICARE ENROLLEES, APRIL 1984[1]

Characteristic	Number of enrollees (in millions)	Percent of enrollees	Percent having neither private supplementary coverage nor Medicaid eligibility
All[2]	25.6	100	20.1
Family Income			
Under $5,000	3.1	12.2	28.5
$5,000 to $8,999	5.6	21.8	29.9
$9,000 to $14,999	6.2	24.1	20.8
$15,000 to $24,999	5.9	22.9	13.7
$25,000 and over	4.9	19.1	10.1
Age			
65 to 69	8.6	33.3	17.3
70 to 74	7.2	28.0	19.1
75 to 79	4.9	19.3	20.1
80 and above	5.0	19.4	26.5
Self-Reported Health Status			
Excellent	6.6	25.6	19.5
Good	9.5	37.1	20.1
Fair	6.4	25.2	20.4
Poor	3.1	12.1	20.8

[1] Details may not add to totals because of rounding.

[2] These estimates apply to the civilian, noninstitutionalized population age 65 and over enrolled in Medicare.

Source: Congressional Budget Office calculations based on the Survey of Income and Program Participation and the 1980 National Medical Care Utilization and Expenditure Survey.

Despite this widespread supplementary coverage, about 5 million—or 20 percent—of elderly Americans had no protection other than Medicare against health care costs. Moreover, the elderly with lower incomes and with greater health care needs were most likely to lack supplementary insurance, as shown in table 5. For example, nearly 30 percent of the elderly with family incomes under $9,000 had neither private coverage nor Medicaid eligibility, compared with 10 percent of those with family incomes over $25,000. Although health care needs rise with age, so did the likelihood of being without supplementary insurance—17 percent of those between 65 and 69 lacked coverage, compared with 27 percent of those 80 and older. Finally, lack of supplementary coverage was not related to health status, largely because Medicaid covers many of the elderly who are most likely to have poor health. Among those who were not eligible for Medicaid, however, those in poor health were least likely to have private insurance—28 percent were not covered, compared with 20 percent for those whose health was good or excellent.[4]

TOTAL HEALTH CARE EXPENDITURES FOR THE ELDERLY

Expenditures for personal health care services for the elderly nearly tripled between 1977 and 1984, rising from $43 billion to an estimated $120 billion (see table 6). Per capita spending rose an average of 13 percent annually during those years, from $1,785 to $4,202 (see table 7).

Government programs (Federal and State) account for two-thirds ($2,823 per capita) of estimated 1984 spending for the aged (see table 8). The most significant of these programs is Medicare which pays for nearly half ($2,051 per capita) of the aged's health bill. Medicaid funds about 13 percent ($536 per capita) of the expenditures. Other Government health programs are the source of roughly 6 percent ($236 per capita) of personal health care expenditures for people 65 years of age and over.

Consumers are responsible for the remaining one-third ($1,379 per capita) of spending for the aged. One-quarter ($1,059 per capita) of the total health bill for the aged was paid by direct patient payments, also termed out-of-pocket expenses. Out-of-pocket payments by the elderly represent the difference between total health expenditures by the aged and known third-party (public expenditures and private insurance) payments. These out-of-pocket payments include Medicare copayments (less any benefits paid for by so-called "medigap" policies), collected reasonable charge reductions, net private health insurance copayments, and the purchase of care not covered by any third party. It is important to note that direct out-of-pocket payments to providers are not the only expenditures by the aged for health care. The aged also pay supplementary medical insurance (SMI or part B) and private health insurance premiums which are not defined as out-of-pocket expenditures. Private health insurance, including medigap policies, covers an additional estimated 7 percent ($304 per capita) of personal health care expenditures for the elderly.

It is difficult to estimate precisely the share of the elderly's income which is spent on health care. There are little data available which examine this question directly. Therefore, these estimates require many assumptions and must be based on data from a variety of sources. The House Select Committee on Aging and the Senate Special Committee on Aging each have developed estimates of these amounts. They both estimated that the elderly's out-of-pocket health care costs as a percentage of mean income were about 12 percent in 1977 and about 15 percent in 1984.[5]

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[4] Part of the explanation is that the decision to purchase private supplementary insurance is directly related to the ability to pay its premiums and those with greater health care needs typically have lower incomes. Factors that lead to loss of coverage or barriers against acquiring coverage may also be important.

[5] House Select Committee on Aging, press release, October 31, 1984. Senate Special Committee on Aging, Medicare and the Health Costs of Older Americans: The Extent and Effects of Cost Sharing, committee print, April 1984.

TABLE 6.—PERSONAL HEALTH CARE EXPENDITURES FOR PEOPLE 65 YEARS OF AGE OR OVER, BY SOURCE OF FUNDS AND TYPE OF SERVICE, 1977 AND 1984

[In millions of dollars]

Year and source of funds	Type of service				
	Total care	Hospital	Physician	Nursing home	Other care
1977					
Total	43,425	18,906	7,782	10,696	6,041
Private	15,669	2,319	3,323	5,424	4,603
Consumer	15,499	2,263	3,320	5,352	4,564
Out-of-pocket	12,706	927	2,147	5,264	4,368
Insurance	2,793	1,336	1,173	88	195
Other private	170	56	3	72	39
Government	27,756	16,587	4,458	5,272	1,438
Medicare	19,171	14,087	4,158	348	578
Medicaid	6,049	733	232	4,453	631
Other government	2,536	1,767	68	470	230
Population (in millions)	24.3				
1984					
Total	119,872	54,200	24,770	25,105	15,798
Private	39,341	6,160	9,827	13,038	10,316
Consumer	38,875	5,964	9,818	12,856	10,237
Out-of-pocket	30,198	1,694	6,468	12,569	9,467
Insurance	8,677	4,270	3,350	287	770
Other private	466	196	9	182	79
Government	80,531	48,040	14,943	12,067	5,482
Medicare	58,519	40,524	14,314	539	3,142
Medicaid	15,288	2,595	467	10,418	1,808
Other government	6,724	4,920	162	1,110	532
Population (in millions)	28.5				

Source: Office of Financial and Actuarial Analysis, Health Care Financing Administration as reported in Waldo, Daniel R., and Helen C. Lazenby. "Demographic characteristics and health care use and expenditures by the aged in the United States: 1977–1984." Health Care Financing Review, Fall 1984 No. 1, p. 1.

TABLE 7.—PERSONAL HEALTH CARE EXPENDITURES PER CAPITA FOR PEOPLE 65 YEARS OF AGE OR OVER, BY SOURCE OF FUNDS AND TYPE OF SERVICE, 1977 AND 1984

Year and source of funds	Type of service				
	Total care	Hospital	Physician	Nursing	Other care
1977					
Total	$1,785	$777	$230	$440	$248
Private	644	95	137	223	189
Consumer	637	93	136	220	188
Out-of-pocket	522	38	88	216	180
Insurance	115	55	48	4	8
Other private	7	2	(1)	3	2
Government	1,141	682	183	217	59
Medicare	788	579	171	14	24
Medicaid	249	30	10	183	26
Other government	104	73	3	19	9
1984					
Total	4,202	1,900	868	880	554
Private	1,379	216	344	457	362
Consumer	1,363	209	344	451	359
Out-of-pocket	1,059	59	227	441	332
Insurance	304	150	117	10	27
Other private	16	7	(1)	6	3
Government	2,823	1,684	524	423	192
Medicare	2,051	1,420	502	19	110
Medicaid	536	91	16	365	63
Other government	236	172	6	39	19

[1] Less than $.50.

Source: Office of Financial and Actuarial Analysis, Health Care Financing Administration as reported in Waldo, Daniel, R., and Helen C. Lazenby. "Demographic characteristics and health care use and expenditures by the aged in the United States: 1977–1984." Health Care Financing Review. Fall 1984 No. 1, p. 1.

TABLE 8.—PERCENT DISTRIBUTION OF PERSONAL HEALTH CARE EXPENDITURES PER CAPITA FOR PEOPLE 65 YEARS OF AGE OR OVER, BY SOURCE OF FUNDS AND TYPE OF SERVICE: 1977 AND 1984

Year and source of funds	Type of service				
	Total care	Hospital	Physician	Nursing home	Other care
1977					
Total per capita	100.0	100.0	100.0	100.0	100.0
Private	36.1	12.3	42.7	50.7	76.2
Consumer	35.7	12.0	42.7	50.0	75.5
Out-of-pocket	29.3	4.9	27.6	49.2	72.3
Insurance	6.4	7.1	15.1	0.8	3.2
Other private	0.4	0.3	.0	0.7	0.6
Government	63.9	87.7	57.3	49.3	23.8
Medicare	44.1	74.5	53.4	3.3	9.6
Medicaid	13.9	3.9	3.0	41.6	10.4
Other government	5.8	9.3	0.9	4.4	3.8
1984					
Total per capita	100.0	100.0	100.0	100.0	100.0
Private	32.8	11.4	39.7	51.9	65.3
Consumer	32.4	11.0	39.6	51.2	64.8
Out-of-pocket	25.2	3.1	26.1	50.1	59.9
Insurance	7.2	7.9	13.5	1.1	4.9
Other private	0.4	0.4	.0	0.7	0.5
Government	67.2	88.6	60.3	48.1	34.7
Medicare	48.8	74.8	57.8	2.1	19.9
Medicaid	12.8	4.8	1.9	41.5	11.4
Other government	5.6	9.1	0.7	4.4	3.4

Source: Office of Financial and Actuarial Analysis, Health Care Financing Administration as reported in Waldo, Daniel, R., and Helen C. Lazenby. "Demographic characteristics and health care use and expenditures by the aged in the United States: 1977–1984." Health Care Financing Review. Fall 1981 No. 1, p. 1.

OUT-OF-POCKET LIABILITIES OF THE ELDERLY UNDER MEDICARE

Although Medicare covers most of the costs of serious illnesses, beneficiaries are responsible for a portion of their health care expenditures on covered services. These enrollee liabilities include Medicare copayments—deductibles and coinsurance under both Hospital Insurance (HI) and Supplementary Medical Insurance (SMI)—and balance-billing by physicians who charge in excess of Medicare's allowed amounts.

In 1987, these out-of-pocket liabilities will average $561 per enrollee (see table 9). On average, 65 percent of copayment costs arise under the SMI program and 35 percent arise under the HI program. More than 50 percent of copayment costs are on the claims of physicians and related suppliers. When balance-billing is considered as well, more than 60 percent of out-of-pocket costs are on physicians' claims. About a third of copayment costs are on hospital inpatient stays, while less than 2 percent is due to coinsurance on stays in skilled nursing facilities or on hospice or home health services. Nearly 14 percent of copayment costs arise in hospital outpatient departments.

Copayment liabilities are highest for enrollees with inpatient stays, and for those with renal disease. Those with hospital inpatient stays comprise 22 percent of the enrollee population, but this group is liable for 70 percent of out-of-pocket costs (see table 10). Enrollees with renal disease are only 0.4 percent of the enrollee population, but they are liable for nearly 4 percent of out-of-pocket costs.

TABLE 9.—MEDICARE ENROLLEES' OUT-OF-POCKET LIABILITIES FOR COVERED SERVICES, BY TYPE OF SERVICE, 1987 [1]

Type of service	Medicare copayments		Balance-billing		Total	
	Dollars per enrollee	Percent of total	Dollars per enrollee	Percent of total	Dollars per enrollee	Percent of total
Total Medicare	456	100.0	105	100.0	561	100.0
Hospital insurance	159	35.0	0	0.0	159	28.4
Inpatient stays	151	33.1	0	0.0	151	26.9
Other	8	1.8	0	0.0	8	1.5
Supplementary medical insurance	296	65.0	105	100.0	401	71.6
Physicians/suppliers	235	51.5	105	100.0	340	60.6
Outpatient departments	62	13.5	0	0.0	62	11.0

[1] The costs shown here represent aged and disabled enrollees' liabilities. Amounts paid by enrollees may be less, because some enrollees' liabilities are paid by Medicaid or are not paid at all.

Source: Preliminary Congressional Budget Office estimates based on 1985 Medicare claims data, projected to 1987.

Only about 20 percent of aged Medicare enrollees actually pay these out-of-pocket liabilities directly, though. Medicare copayment costs are paid by Medicaid for the 8 percent of enrollees who are dually eligible. Another 72 percent of enrollees have medigap insurance that pays most of their Medicare copayment costs, in exchange for additional premiums that will average between $500 and $600 in 1987. As a result, enrollees' actual payments (including both out-of-pocket costs and medigap insurance premiums) are much more uniform across types of enrollees than is apparent in table 10.

TABLE 10.—MEDICARE ENROLLEES' OUT-OF-POCKET LIABILITIES FOR COVERED SERVICES, BY TYPE OF ENROLLEE, 1987 [1]

Enrollee group	Percent of enrollees in group	HI copayments		SMI copayments		Balance-billing		Total	
		Dollars per enrollee	Percent of total	Dollars per enrollee	Percent of total	Dollars per enrollee	Percent of total	Dollars per enrollee	Percent of total
All enrollees	100.0	159	100.0	296	100.0	105	100.0	561	100.0
Male	42.3	163	43.2	305	43.5	114	45.8	581	43.9
Female	57.7	157	56.8	290	56.5	99	54.2	546	56.1
Under age 65	9.9	176	11.0	369	12.4	65	6.1	609	10.8
Age 65 to 69	33.2	112	23.3	247	27.7	99	31.2	457	27.1
Age 70 to 74	18.3	146	16.8	292	18.1	116	20.3	555	18.1
Age 75 to 79	17.5	173	19.0	321	19.0	126	21.0	620	19.4
Age 80 to 84	11.4	209	14.9	332	12.8	118	12.8	659	13.4
Age 85 or more	9.6	249	15.0	312	10.1	95	8.7	656	11.2
Aged:									
Without renal disease	90.4	156	88.4	281	85.7	109	93.8	546	88.0
With renal disease	0.1	856	0.7	4,643	2.1	234	0.3	5,733	1.4
Disabled:									
Without renal disease	9.2	172	9.9	273	8.5	64	5.6	508	8.4
With renal disease	0.3	550	0.9	4,109	3.7	138	0.4	4,796	2.3
No reimbursable services	28.4	0	0.0	37	3.6	0	0.0	37	1.9
Reimbursable services, with:									
No inpatient stays	49.7	1	0.4	243	40.8	73	34.3	317	28.1
One stay	14.5	520	47.4	563	27.6	252	34.8	1,335	34.6
Two or more stays	6.9	827	35.7	1,079	25.0	440	28.8	2,346	28.8
One or more stays, with coinsurance days	0.5	5,391	16.5	1,809	3.0	457	2.1	7,657	6.7

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[1] The costs shown here represent aged and disabled enrollees' liabilities. Amounts paid by enrollees may be less, because some enrollees' liabilities are paid by Medicaid or by supplementary private insurance, or some liabilities are not paid at all. For those enrollees who purchase medigap insurance, the burden of costs (including both out-of-pocket costs and medigap insurance premiums) is more uniform across types of enrollees than shown here, because medigap coverage greatly reduces enrollees' copayment costs in return for their paying private insurance premiums.

Source: Preliminary Congressional Budget Office estimates based on 1985 Medicare claims data, projected to 1987.

TABLE 11.—MEDICARE UTILIZATION AND REIMBURSEMENT—NUMBER OF AGED PERSONS SERVED UNDER HOSPITAL INSURANCE AND/OR SUPPLEMENTARY MEDICAL INSURANCE PER 1,000 ENROLLED, AMOUNT REIMBURSED PER PERSON SERVED, AND PERCENT CHANGE, BY CENSUS DIVISION AND STATE

Census division and State	Persons served per 1,000 enrolled					Reimbursement per person served				
	1967	1982	1983	Annual percent change		1967	1982	1983	Annual percent change	
				1967–1982	1982–1983				1967–1982	1982–1983
Total, all areas [1]	366.5	641.4	660.2	3.8	2.9	$592	$2,439	$2,611	9.9	7.1
United States [2]	370.9	650.0	668.7	3.8	2.9	593	2,446	2,618	9.9	7.0
New England	380.4	696.9	719.4	4.1	3.2	680	2,393	2,547	8.7	6.4
Maine	330.1	671.6	701.3	4.8	4.4	586	2,176	2,359	9.1	8.4
New Hampshire	391.6	658.1	669.2	3.5	1.7	467	2,174	2,312	10.8	6.3
Vermont	411.7	677.2	683.4	3.4	0.9	515	2,073	1,888	9.7	−8.9
Massachusetts	394.2	700.3	724.5	3.9	3.5	708	2,681	2,817	9.3	5.1
Rhode Island	375.4	769.1	796.8	4.9	3.6	625	1,994	2,137	8.0	7.2
Connecticut	390.9	689.8	710.4	3.9	3.0	711	2,171	2,409	7.7	11.0
Middle Atlantic	388.1	688.6	709.2	3.9	3.0	578	2,428	2,658	10.0	9.5
New York	406.9	703.8	724.8	3.7	3.0	610	2,343	2,570	9.4	9.7
New Jersey	399.0	687.6	701.7	3.7	2.1	526	2,386	2,641	10.6	10.7
Pennsylvania	365.0	668.4	692.3	4.1	3.6	533	2,574	2,792	11.1	8.5
East North Central	350.2	630.1	656.4	4.0	4.2	614	2,687	2,764	10.3	2.9
Ohio	353.6	630.2	654.5	3.9	3.9	585	2,579	2,629	10.4	1.9
Indiana	343.7	598.7	625.8	3.8	4.5	545	2,428	2,371	10.5	−2.3
Illinois	339.2	589.7	615.0	3.8	4.3	703	3,072	3,194	10.3	4.0
Michigan	379.5	712.2	738.1	4.3	3.6	532	2,702	2,816	11.4	4.2
Wisconsin	354.7	615.6	648.2	3.7	5.3	639	2,346	2,457	9.1	4.7
West North Central	363.2	617.3	620.0	3.6	0.4	558	2,349	2,471	10.1	5.2
Minnesota	389.0	621.3	626.6	3.2	0.9	601	2,146	2,236	8.9	4.2

TABLE 11.—MEDICARE UTILIZATION AND REIMBURSEMENT—NUMBER OF AGED PERSONS SERVED UNDER HOSPITAL INSURANCE AND/OR SUPPLEMENTARY MEDICAL INSURANCE PER 1,000 ENROLLED, AMOUNT REIMBURSED PER PERSON SERVED, AND PERCENT CHANGE, BY CENSUS DIVISION AND STATE—Continued

Census division and State	Persons served per 1,000 enrolled					Reimbursement per person served				
	1967	1982	1983	Annual percent change		1967	1982	1983	Annual percent change	
				1967–1982	1982–1983				1967–1982	1982–1983
Iowa	365.9	613.0	626.8	3.5	2.3	505	2,156	2,275	10.2	5.5
Missouri	364.8	603.6	586.6	3.4	−2.8	544	2,667	2,871	11.2	7.6
North Dakota	441.2	665.3	701.0	2.8	5.4	492	2,413	2,433	11.2	0.8
South Dakota	358.0	585.7	613.4	3.3	4.7	514	2,228	2,312	10.3	3.8
Nebraska	352.5	575.6	599.4	3.3	4.1	540	2,220	3,357	9.8	7.1
Kansas	365.3	669.9	664.7	4.1	−0.8	540	2,376	2,448	10.4	3.0
South Atlantic	350.5	653.4	673.8	4.2	3.1	554	2,310	2,503	10.0	8.4
Delaware	368.2	680.2	718.3	4.2	5.6	552	2,119	2,364	9.4	11.6
Maryland	349.4	667.3	695.0	4.4	4.2	564	2,764	3,010	11.2	8.9
District of Columbia	452.8	691.6	718.4	2.9	3.9	570	3,622	3,796	13.1	4.8
Virginia	317.3	622.2	652.5	4.6	4.9	516	2,170	2,360	10.0	8.8
West Virginia	342.2	577.8	610.9	3.6	5.7	489	2,283	2,304	10.8	0.9
North Carolina	324.0	588.8	616.4	4.1	4.7	515	1,995	2,122	9.4	6.4
South Carolina	296.2	585.1	598.5	4.6	2.3	523	1,990	2,097	9.3	5.4
Georgia	320.2	632.1	653.6	4.6	3.4	474	1,982	2,258	10.0	13.9
Florida	420.9	710.6	721.6	3.6	1.5	588	2,437	2,651	9.9	8.8
East South Central	332.1	589.5	612.0	3.9	3.8	489	2,232	2,375	10.7	6.4
Kentucky	365.9	552.7	577.4	2.8	4.5	458	2,269	2,350	11.3	3.6
Tennessee	354.8	583.3	600.4	3.4	2.9	502	2,225	2,493	10.4	12.0
Alabama	322.7	621.4	646.0	4.5	4.0	490	2,303	2,315	10.9	0.5
Mississippi	283.2	604.2	630.6	5.2	4.4	471	2,084	2,298	10.4	10.3
West South Central	374.8	606.6	626.7	3.3	3.3	504	2,371	2,627	10.9	10.8
Arkansas	319.3	616.8	134.2	4.5	2.8	466	2,051	2,249	10.4	9.7
Louisiana	343.4	559.0	566.7	3.3	1.4	446	2,445	2,686	12.0	9.9

Oklahoma	416.1	599.2	618.2	2.5	3.2	486	2,281	2,550	10.9	11.8
Texas	393.7	619.8	644.4	3.1	4.0	522	2,448	2,716	10.9	10.9
Mountain	417.1	640.9	651.7	2.9	1.7	560	2,237	2,337	9.7	4.5
Montana	416.5	618.0	625.0	2.7	1.1	505	2,124	2,219	10.1	4.5
Idaho	408.8	625.5	655.3	2.9	4.8	467	1,921	2,009	9.9	4.6
Wyoming	395.0	568.4	592.4	2.5	4.2	432	2,446	2,304	12.3	−5.8
Colorado	475.4	657.8	660.4	2.2	0.4	578	2.300	2,453	9.6	6.7
New Mexico	377.6	622.3	636.8	3.4	2.3	513	2,064	2,411	9.7	16.8
Arizona	431.7	668.8	676.9	3.0	1.2	612	2,239	2,334	9.0	4.2
Utah	346.0	598.6	620.5	3.7	3.7	580	1,931	1,913	8.3	−0.9
Nevada	414.9	645.7	642.6	3.0	−0.5	532	3,174	3,043	12.6	−4.1
Pacific	468.9	689.2	700.8	2.6	1.7	630	2,624	2,834	10.0	8.0
Washington	433.0	667.9	683.2	2.9	2.3	507	1,944	2,147	9.4	10.4
Oregon	392.6	630.6	663.5	3.2	5.2	583	2,315	2,499	9.6	7.9
California	490.7	702.3	710.8	2.4	1.2	653	2,788	3,008	10.2	7.9
Alaska	307.2	644.7	632.1	5.1	−2.0	376	2,756	2,944	14.2	6.8
Hawaii	407.4	649.4	654.1	3.2	0.7	572	2,307	2,432	9.7	5.4

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[1] Consists of United States and other areas not shown separately.

[2] Consists of 50 States, District of Columbia, and residence unknown.

Source: Bureau of Data Management and Strategy, Health Care Financing Administration: Data from the Medicare Statistical System.

TABLE 12.—NUMBER, PERCENT DISTRIBUTION, AND RATE OF NURSING HOME RESIDENTS 65 YEARS OF AGE AND OVER BY AGE, SEX, AND RACE: UNITED STATES, 1985

Age, sex, and race	Number of residents	Percent distribution	Number of residents per 1,000 population 65 years and over [1]
Total	1,315,800	100.0	46.1
Age			
65 to 74 years	212,100	16.1	12.5
75 to 84 years	509,000	38.7	57.7
85 years and over	594,700	45.2	219.4
Sex			
Male	334,000	25.4	29.0
Female	981,900	74.6	57.7
Race			
White	1,224,900	93.1	47.6
Black	82,000	6.2	35.0
Other	8,900	0.7	20.1

[1] Population data used to compute rates are from—U.S. Bureau of the Census: Estimates of the population of the United States by age, sex, and race, 1980 to 1985. Current Population Reports. Series P–25. No. 985. Washington, U.S. Government Printing Office, April 1986.

Source: National Center for Health Statistics, Advance data, May 1987.

TABLE 13.—SELECTED FACILITY CHARACTERISTICS FOR NURSING HOMES, 1973–74, 1977 AND 1985

Survey year	Facility characteristics				
	Homes	Beds	FTE's [1] per 100 beds	Current residents	Beds per 1,000 persons 65 years or over
1973–74	15,700	1,177,300	41.2	1,075,800	55.2
1977	18,900	1,402,400	46.2	1,303,100	59.7
1985	19,100	1,624,200	48.9	1,491,400	56.9

[1] Includes only those providing direct patient care: Administrative, medical, and therapeutic staff; registered nurses; licensed practical nurses; nurse's aides; and orderlies. The FTE's are calculated by dividing part-time hours by 35 and adding the results to full-time employees.

Source: National Center for Health Statistics, Advance data, March 1987.

TABLE 14.—PERCENT OF THE 65-PLUS POPULATION IN THE COMMUNITY WITH ADL LIMITATIONS

Age/sex	Type of dependency				
	Only IADL limited [1]	ADL (activity of daily living limitation) scores [2]			Total
		1–2 (mildly disabled)	3–4 (disabled)	5–6 (severely disabled)	
65 to 74	4.5	4.2	1.8	2.1	12.6
Male	4.2	3.4	1.7	2.4	11.7
Female	4.8	4.7	1.9	1.9	13.3
75 to 84	7.9	9.0	3.6	4.5	25.0
Male	7.1	6.5	2.5	4.6	20.9
Female	8.5	10.3	4.3	4.4	27.6
85+	10.2	17.4	7.8	10.4	45.8
Male	9.9	15.7	7.7	7.5	40.8
Female	10.3	18.2	7.9	11.8	48.2
All 65+	6.0	6.6	2.8	3.5	18.9
Male	5.4	5.1	2.3	3.3	16.0
Female	6.4	7.7	3.2	3.6	20.9

[1] Needs assistance with the instrumental activities of daily living (IADL): managing money, shopping, light housework, meal preparation, making a phone call, and taking medication.

[2] Sum of the number of activities of daily living (ADL) with which respondent requires assistance: eating, bathing, dressing, toileting, etc.

Source: Tabulations from the 1982 Long-Term Care Survey prepared by the Center for Demographic Studies, Duke University. Reported by Soldo, Beth J., and Manton, Kenneth G., Health Service Needs of the Oldest Old, Health and Society, Milbank Memorial Fund Quarterly, Vol. 63, No. 2, Spring 1983.

TABLE 15.—ESTIMATED SPENDING FOR LONG-TERM CARE IN FISCAL YEAR 1985, BY TYPE OF SERVICE AND PAYMENT SOURCE [1]

[In billions of dollars]

Source of payment	Nursing home care [2]	Home health services [3]	Total	Distribution of total spending by source (in percent)
Total	35.8	9.1	44.9	100
Federal	10.9	3.5	14.4	32
Medicare	0.6	2.3	2.9	7
Medicaid	9.5	0.6	10.0	22
VA and other [4]	0.8	0.6	1.5	3
State/local	8.2	1.0	9.1	20
Medicaid	7.7	0.5	8.2	18
Other [5]	0.4	0.5	0.9	2
Private (formal)	16.7	4.6	21.3	48
Out-of-pocket	16.2	3.7	19.8	44
Other [6]	0.6	0.9	1.5	3

[1] The data in this table include "formal" long-term care only. "Formal" care denotes paid services or care received through the market, whereas "informal" care, an invisible cost, is free assistance given by families and friends. Only about one-fourth of the functionally disabled elderly currently receive formal care.

[2] Nursing home care includes services provided in skilled nursing facilities, intermediate care facilities, combinations of skilled and intermediate nursing facilities, intermediate care facilities for the mentally retarded, and noncertified facilities providing some nursing care.

[3] The home health services included are: nursing care, speech therapy, physical therapy, occupational therapy, services provided by home health aides, and medical social services. Payments for adult day care, meals, and transportation services are excluded.

[4] Federal payments for home health services are also provided under the Older Americans Act and the social services block grant.

[5] Other State funding consists mainly of Medicaid-related payments for which there was no Federal matching.

[6] Other private sources of payment include private organizations and private insurers.

Source: Congressional Budget Office preliminary calculations based on estimates from the Actuarial Research Corp.

Note: Details may not add to totals because of rounding.

APPENDIX C. NATIONAL HEALTH CARE EXPENDITURES AND HEALTH INSURANCE COVERAGE

National Health Expenditures

During 1965 (the year prior to the beginning of the Medicare and Medicaid programs), national health expenditures were $41.9 billion; by 1986, annual expenditures were $458 billion, almost 11 times that amount. Hospital care expenditures are the largest component of national health expenditures, representing 39.2 percent of total national health spending in 1986. In terms of per capita spending, $720 was spent for hospital care per capita in 1986 compared to $676 in 1985, an increase of 6.5 percent (see table 2).

Of the various sources of payment for personal health care expenditures in 1986, 30.4 percent ($122.9 billion) was paid by private health insurance, 18.8 percent ($76 billion) was paid by Medicare, 11.3 percent ($45.8 billion) was paid by other Federal sources (including Medicaid), 9.4 percent ($38.1 billion) was paid by State and local sources, and 28.7 percent ($116.1 billion) was paid by direct (out-of-pocket) payments by individuals. A little over 1 percent was paid by philanthropy and in-plant health services (see table 3).

TABLE 1.—NATIONAL HEALTH EXPENDITURES: AGGREGATE AMOUNTS FOR SELECTED CALENDAR YEARS 1965, 1970, 1975, 1980, 1985, and 1986

[Amount in billions]

	1965	1970	1975	1980	1985	1986
Total	$41.9	$75.0	$132.7	$248.1	$422.6	$458.2
Percent of GNP	5.9	7.4	8.3	9.1	10.6	10.9
Health services and supplies	$38.4	$69.6	$124.3	$236.2	$407.2	442.0
Personal health care	35.9	65.4	117.1	219.7	371.3	404.0
Hospital care	14.0	28.0	52.4	101.6	167.2	179.6
Physicians' services	8.5	14.3	24.9	46.8	82.8	92.0
Dentists' services	2.8	4.7	8.2	15.4	27.1	29.6
Other professional services	1.0	1.6	2.6	5.7	12.4	14.1
Drugs and medical sundries	5.2	8.0	11.9	18.8	28.7	30.6
Eyeglasses and appliances	1.2	1.9	3.2	5.1	7.5	8.2
Nursing home care	2.1	4.7	10.1	20.4	35.0	38.1
Other health services	1.1	2.1	3.8	5.9	10.8	11.9
Program administration and net cost of private health insurance	1.7	2.8	4.0	9.2	23.6	24.5
Government public health activities	0.8	1.4	3.2	7.3	12.3	13.4
Research, and construction of medical facilities	3.5	5.4	8.4	11.9	15.4	16.3

Note: Totals may not add due to rounding.

Source: Office of the Actuary, Office of National Cost Estimates, Health Care Financing Administration: "National Health Expenditures, 1986–2000," Health Care Financing Review, Summer 1987, p. 26.

TABLE 2.—NATIONAL HEALTH EXPENDITURES: PER CAPITA AMOUNTS FOR SELECTED CALENDAR YEARS 1965, 1970, 1975, 1980, 1985, AND 1986

[Dollar amount per capita]

	1965	1970	1975	1980	1985	1986
Total	$205	$349	$590	$1,054	$1,710	$1,837
Health services and supplies	188	324	553	1,004	1,647	1,772
Personal health care	176	304	521	934	1,502	1,620
Hospital care	69	130	233	432	676	720
Physicians' services	42	66	111	199	335	369
Dentists' services	14	22	36	65	110	119
Other professional services	5	7	12	24	50	56
Drugs and medical sundries	25	37	53	80	116	122
Eyeglasses and appliances	6	9	14	22	30	33
Nursing home care	10	22	45	87	141	153
Other health services	5	10	17	25	44	48
Program administration and net cost of private health insurance	8	13	18	39	96	98
Government public health activities	4	7	14	31	50	54
Research, and construction of medical facilities	17	25	37	51	62	65

Note: Totals may not add due to rounding.

Source: Office of the Actuary, Office of National Cost Estimates, Health Care Financing Administration: "National Health Expenditures, 1986–2000," Health Care Financing Review, Summer 1987, p. 24.

TABLE 3.—PERSONAL HEALTH CARE EXPENDITURES: AGGREGATE AMOUNTS AND PERCENTAGE DISTRIBUTION FOR SELECTED CALENDAR YEARS 1965, 1970, 1975, 1980, 1985, AND 1986

	1965	1970	1975	1980	1985	1986
	Amount in billions					
Total	$35.9	$65.4	$117.1	$219.1	$371.3	$404.0
Private	28.0	42.9	70.9	133.2	222.9	244.1
Private health insurance	8.7	15.3	31.2	67.5	113.0	122.9
Patient direct payments	18.5	26.5	38.1	63.0	105.3	116.1
Philanthropy and in-plant health services	0.8	1.1	1.6	2.7	4.6	5.0
Public	7.9	22.4	46.3	86.5	148.3	160.0
Federal	3.6	14.5	31.4	62.5	112.7	121.8
State and local	4.3	7.9	14.9	24.0	35.7	38.1
	Percentage distribution					
Total	100.0	100.0	100.0	100.0	100.0	100.0
Private	78.0	65.6	60.5	60.6	60.0	60.3
Private health insurance	24.2	23.4	26.7	30.7	30.4	30.4
Patient direct payments	51.6	40.5	32.5	28.7	28.4	28.7
Philanthropy and in-plant health services	2.2	1.7	1.3	1.2	1.2	1.2
Public	22.0	34.3	39.5	39.3	39.9	39.6
Federal	10.1	22.2	26.8	28.4	30.3	30.2
State and local	11.9	12.1	12.7	10.9	9.6	9.4

Note: Totals may not add due to rounding.

Source: Office of the Actuary, Office of National Cost Estimates, Health Care Financing Administration: "National Health Expenditures, 1986–2000," Health Care Financing Review, Summer 1987, p. 29.

EXPENDITURES FOR HOSPITAL CARE

The American Hospital Association (AHA) compiles detailed measures of expenses of the Nation's community hospitals, which are defined as all non-Federal short-term general and other special hospitals (excluding after 1971 hospital units of institutions) whose facilities and services are available to the public. Table 4 shows historical expense data for community hospitals from the AHA's National Hospital Panel Survey. The Survey is a monthly survey of a randomly selected sample of about 1,800 of the approximately 5,800 community hospitals.

The total expenses of community hospitals, including expenses for both inpatent and outpatient care, were $146 billion in 1986, an increase of 219 percent over the preceding 10 years. The average cost of a day of hospital care was $535 in 1986, representing a 10-year increase of 239 percent. The increase in hospital inpatient costs per admission, or "cost per case" over the past 10 years was 202 percent, rising to $3,527 in 1986.

Table 4 displays, for measures of hospital expense, data for the years 1965 to 1986. The rate of growth in hospital expenses exceeded the rate of inflation as measured by the CPI in most years. In general, changes in the rate of growth in hospital expenses have followed changes in inflation. For example, the medical care component of the CPI and the rates of growth in the adjusted expenses per inpatient day and per admission were all relatively low during the Economic Stabilization Program (August 1971 through 1974). Also, the rates of increase of all four measures of community hospital expenses have been following the CPI downward since 1981. A short-term downward trend in the growth rate of hospital expenses which is not reflected in the CPI indexes is evident in the 1976 to 1979 interval. Some analysts have argued that this was due perhaps in part to the initiation in 1978 of a "voluntary effort" to reduce health care costs initiated by the American Hospital Association and other health organizations.

TABLE 4.—SELECTED COMMUNITY HOSPITAL EXPENSES DATA, TOTALS AND PERCENTAGE INCREASES, 1965–1986

[Dollars in billions]

Year	Total expenses		Adjusted [1] expenses per inpatient day		Adjusted expenses per admission		Inpatient expenses	
	Amount	Percent change	Amount	Percent change	Amount	Percent change	Amount	Percent change
1965	$9.220	8.6	$41	7.5	$315	8.1	$8.414	8.7
1966	10.497	13.8	46	12.2	356	13.0	9.611	14.2
1967	12.624	20.3	53	15.2	425	19.4	11.551	20.2
1968	14.720	16.6	59	11.3	482	13.4	13.371	15.8
1969	17.247	17.2	68	15.2	551	14.3	15.635	16.9
1970	20.261	17.5	78	14.7	608	10.3	18.328	17.2
1971	22.496	11.0	87	11.5	670	10.2	20.269	10.6
1972	25.223	12.1	96	10.3	729	8.8	22.622	11.6
1973	28.248	12.0	105	9.4	784	7.5	25.173	11.3
1974	32.759	16.0	118	12.4	873	11.4	29.077	15.5
1975	38.492	17.5	138	16.9	1,017	16.5	33.971	16.8
1976	45.842	19.1	158	14.5	1,168	14.8	40.321	18.7
1977	53.006	15.6	181	14.5	1,312	12.3	46.437	15.2
1978	59.802	12.8	203	12.2	1,466	11.7	52.131	12.3
1979	67.833	13.4	226	11.3	1,618	10.4	59.060	13.3
1980	79.340	17.0	256	13.3	1,836	13.5	68.962	16.8
1981	94.187	18.7	299	16.8	2,155	17.4	81.651	18.4
1982	109.091	15.8	348	16.4	2,489	15.5	94.346	15.5
1983	120.220	10.2	391	12.5	2,742	10.2	103.403	9.5
1984	126.028	4.6	443	13.3	2,947	7.5	107.000	3.2
1985	134.043	6.6	493	11.2	3,226	9.4	111.402	4.4
1986	146.032	8.9	535	8.6	3,527	9.3	119.281	7.1

[1] Adjusted to account for the volume of outpatient visits.

Note: Percentage changes may not correspond to published data because of rounding.

Source: National Hospital Panel Survey, American Hospital Association.

A variety of factors other than overall inflation contribute to aggregate changes in hospital expenses, including: population growth, factors such as aging of the population which affect admission rates, inflation over and above general inflation in the prices of goods and services purchased by the hospitals (input factor prices), and changes in the type and mix (intensity) of services rendered due to such factors as changes in the use of technology or treatment patterns. Arnett et al. (Health Care Financing Review, spring 1986) estimated that over 51 percent of the overall growth in inpatient hospital expenses between 1974 and 1984 was due to overall inflation, approximately 7.3 percent to population growth, 16.6 percent to excess inflation in hospital prices, and 33.4 percent to intensity of services per day. The recent decline in the number of inpatient days per capita has exerted downward pressure on inpatient hospital expenses. This decline held the growth in these expenses between 1974 and 1984 to 8.5 percent below what otherwise would have occurred.

Expenditures for hospital care are financed primarily by third parties (see table 5). In 1986, private health insurers paid 36 percent of the total, Medicare and Medicaid paid 38 percent, and other government programs paid 15 percent. The amount financed directly by consumers was 9.4 percent, up from 8.7 percent in 1986. HCFA attributes the increase in direct consumer payments to changes in third-party financing and in coverage. Medicare beneficiaries were liable for increased deductible and coinsurance amounts in 1986, because of changes in the cost per day of hospital care. Many privately insured employees and dependents faced similar changes in copayment requirements as employers pared down their contributions to paying for health care costs. HCFA also suggests that this increase may be partly explained by the rising number of Americans who are uninsured.

Table 5 also shows that the Medicare share of spending dropped from 1985 to 1986. This is the first decrease since the early 1970's. HCFA has attributed this decline to the relatively low growth in Medicare payments per hospital admission (see table 6 on Medicare hospital insurance trust fund expenditures).

TABLE 5.—EXPENDITURES FOR HOSPITAL CARE, BY SOURCE OF FUNDS, 1980, 1985, AND 1986

[Amounts in billions]

Source of payment	1980		1985		1986	
	Amount	Percent	Amount	Percent	Amount	Percent
Total	$101.6	100.0	$167.2	100.0	$179.6	100.0
Direct Payments	7.9	7.8	14.5	8.7	16.8	9.4
Third-party payments	93.7	92.2	152.7	91.3	162.8	90.6
Private health insurance	38.7	38.1	60.5	36.2	64.9	36.1
Philanthropy and industrial in-plant	1.1	1.1	2.0	1.2	2.2	1.2

TABLE 5.—EXPENDITURES FOR HOSPITAL CARE, BY SOURCE OF FUNDS, 1980, 1985, AND 1986—Continued

[Amounts in billions]

Source of payment	1980		1985		1986	
	Amount	Percent	Amount	Percent	Amount	Percent
Government	53.9	53.1	90.2	54.0	95.7	53.3
Federal	41.1	40.4	72.0	43.1	76.5	42.6
Medicare [1]	25.9	25.5	48.9	29.2	51.7	28.8
Medicaid [2]	9.6	9.4	14.9	8.9	15.8	8.8
State and local	12.8	12.6	18.3	10.9	19.2	10.7

[1] Subset of Federal funds

[2] Subset of Federal, State and local funds.

Source: Office of the Actuary, Office of National Cost Estimates, Health Care Financing Administration: "National Health Expenditures, 1986–2000," Health Care Financing Review, Summer 1987, p.30

TABLE 6.—HISTORICAL AND PROJECTED INCREASES IN HI HOSPITAL INPATIENT EXPENDITURES, BY COMPONENT OF INCREASE, 1975–2000

[Percent increase over previous year]

Calendar year	HI hospital inpatient expenditures	HI inpatient admission volume	Hospital market basket index	Service intensity and productivity [1]
	Historical rates			
1975	22.5	3.5	10.2	7.4
1976	19.2	4.4	7.4	6.3
1977	17.2	7.7	7.3	1.4
1978	14.9	0.7	7.3	6.3
1979	16.5	5.9	8.8	1.1
1980	20.8	4.6	11.8	3.3
1981	19.7	4.8	10.1	3.7
1982	15.8	1.8	7.7	5.6
1983	11.2	2.7	5.4	2.7
1984	10.9	−2.4	4.9	8.3
1985	5.9	−5.6	3.8	8.1
	Projected rates [2]			
1986	3.0	−1.0	3.0	1.0
1987	4.2	3.0	3.7	−2.4
1988	7.8	1.9	5.3	0.5
1989	10.4	3.4	5.3	1.4
1990	11.0	3.7	5.9	1.1
1995	8.8	2.6	5.5	0.5
2000	7.8	1.9	5.7	0.1

[1] A residual category; that part of annual growth in HI hospital inpatient expenditures not accounted for by growth in HI admissions or increases in the market basket index.

[2] Based on alternative II–B economic assumptions.

Source: Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund, 1987, table A1, p. 71.

EXPENDITURES FOR PHYSICIANS' SERVICES

Personal health care expenditures for physicians' services were $92.0 billion in 1986, an increase of 11 percent from the previous year (see Table 1). In 1986, 22.8 percent of personal health care expenditures and 20 percent of all national health expenditures were for physicians' services. (See Table 1). Physicians, however, affect personal health care expenditures more than this might indicate. Physicians have considerable discretion in determining price and volume of all medical services. It is estimated that physicians' decisions (such as ordering hospitalizations, drugs, laboratory tests) directly influence over 70 percent of all health care spending.

Third-party (public expenditures and private insurance) payments financed a large majority of physicians' services. In 1986, private health insurance paid $38.7 billion (42.1 percent) for such services. The remainder was split relatively evenly between direct patient payments and public expenditures. Patients or their families paid $26.2 billion (28.5 percent) for physicians' services. Public programs paid $27.1 billion (29.4 percent) for such services, of which $19.0 billion (20.6 percent) was composed of Federal Medicare payments (see table 7).

Inflation was a major cause of growth in spending for physicians' services. Physicians' fees have risen more rapidly (7.5 percent in 1986) than prices in the economy as a whole (3.4 percent in 1986), as measured by the Consumer Price Index (CPI) (see table 8).

Expenditures for physicians' services over a 10-year span increased from $21.2 billion in 1974 to $75.4 billion in 1984, an annual growth rate of about 13.5 percent. Of this 10-year expenditure growth, increases in overall inflation accounted for 52.8 percent, increases in the medical care price increases in excess of general price inflation accounted for 19.7 percent, and increased intensity per visit for 27.5 percent. A change in the number of visits per person had the effect of decreasing the growth in physician expenditures by 7.5 percent.

According to the Health Care Financing Administration, if the change in physician expenditures is examined just for the period 1985–1986, the factors accounting for the growth look very different. Increases in overall inflation accounted for 25.3 percent, increases in medical care prices in excess of general inflation accounted for 41.1 percent, and increased intensity per visit accounted for 22.4 percent. A change in the number of visits per person had the effect of increasing the growth in physician expenditures by 2.8 percent, while changes in the population accounted for 8.4 percent.

The average 1986 net income after expenses but before taxes for physicians was $119,500, an increase of 6.5 percent over the previous year (see table 9). Radiologists experienced the highest growth in average net income, 11.9 percent, and also led all specialty groups with an average net income of $168,800. In contrast, the net income of general practioners/family practice physicians rose by 3.1 percent. By region, average net income growth rates varied greatly, ranging from −1.1 percent in New England to 11.3 percent in the Mountain region. Physicians in the West South Central and East North Central Regions had the highest average net incomes ($129,000 and $126,600 respectively). Physicians in New England had the lowest average net income ($107,100). The growth rates between rural and urban areas varied between 14.3 percent in nonmetropolitan areas and 5.4 percent in metropolitan areas with less than 1 million population and 4.2 percent in metropolitan areas with more than 1 million population. The average net income of self-employed physicians ($131,100) continued to be higher than the average net income of employee physicians ($91,700).

The 1982 continuing survey of physicians' income conducted by Medical Economics [1] showed that the typical office-based doctor received two-thirds of his 1981 gross practice income from third parties (see table 8). On the average, 21 percent came from commercial health insurance, 20 percent from Blue Shield, 17 percent from Medicare, and 8 percent from Medicaid. Table 8 also shows the breakdown of gross practice income from each third party. For example, thoracic surgeons on average receive 35 percent ($72,420 per capita) of their gross income from Medicare, while pediatricians on average gain only 1 percent ($1,170 per capita) of their gross incomes from Medicare.

TABLE 7.—PERSONAL HEALTH CARE EXPENDITURES FOR PHYSICIAN SERVICES [1] BY SELECTED THIRD-PARTY PAYERS: CALENDAR YEARS 1983–1986

[Amounts in billions]

Source of payment	1983		1984		1985		1986	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Total	$68.4	100.0	$75.4	100.0	$82.8	100.0	$92.0	100.0
Direct payments	18.9	27.7	21.0	27.8	23.0	27.8	26.2	28.5
Third-party payments	49.5	72.3	54.4	72.2	59.7	72.2	64.9	71.5
Private health insurance	30.1	44.0	33.5	44.4	35.5	42.9	38.7	42.1
Philanthropy and industrial inplant	([2])	([2])	([2])	([2])	([2])	([2])	([2])	([2])
Government	19.3	28.3	20.9	27.8	24.2	29.3	27.1	29.4
Federal	15.6	22.8	16.9	22.4	19.7	23.8	22.0	24.0
Medicare [3]	13.4	19.5	14.6	19.3	16.9	20.5	19.0	20.6
Medicaid [4]	1.6	2.3	1.7	2.2	2.0	2.4	2.3	2.5
Other	.6	.9	.7	.9	.7	.9	.8	.9
State and local	3.8	5.5	4.1	5.3	4.5	5.5	5.0	5.5
Medicaid [4]	1.3	2.0	1.4	1.8	1.6	1.9	1.7	1.8
Other	2.4	3.5	2.6	3.5	3.0	3.6	3.3	3.6

[1] Encompasses the cost of all services and supplies provided in physicians' offices, the cost for services of private practitioners in hospitals and other institutions, and the cost of diagnostic work performed in independent clinical laboratories. The salaries of staff physicians are counted with expenditures for the services of the employing institution.

[2] Less than $50 million.

[3] Represents total expenditures from funds for benefits. Trust fund income includes premium payments paid by or on behalf of enrollees.

[4] Includes funds paid into Medicare trust funds by States under "buy-in" agreements to cover premiums for public assistance recipients and for persons who are medically indigent.

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[1] Owens, Arthur, "How Much of Your Income Comes From Third Parties?" in Medical Economics, April 4, 1983.

Source: Office of the Actuary, Office of National Cost Estimates, Health Care Financing Administration: "National Health Expenditures, 1986–2000," Health Care Financing Review, Summer 1987, p. 31.

TABLE 8.—ANNUALIZED RATES OF CHANGE IN THE CONSUMER PRICE INDEX (CPI–U),[1] 1965–87

	CPI all items	CPI, all items less medical care	Medical care total	Physicians' services
1965	1.7	1.5	2.5	3.6
1966	2.9	3.0	4.4	5.8
1967	2.9	2.4	7.1	7.1
1968	4.2	4.1	6.1	5.6
1969	5.4	5.4	6.9	6.9
1970	5.9	5.8	6.3	7.5
1971	4.3	4.1	6.5	6.9
1972	3.3	3.3	3.2	3.1
1973	6.2	6.4	3.9	3.3
1974	11.0	11.1	9.3	9.2
1975	9.1	8.9	12.0	12.3
1976	5.8	5.5	9.5	11.3
1977	6.5	6.2	9.6	9.3
1978	7.7	7.6	8.4	8.3
1979	11.3	11.4	9.3	9.2
1980	13.5	13.6	10.9	10.6
1981	10.4	10.3	10.8	11.0
1982	6.1	5.9	11.6	9.4
1983	3.2	2.9	8.7	7.7
1984	4.3	4.1	6.2	7.0
1985	3.8	3.6	6.7	6.9
1986	1.9	1.5	7.5	7.2
1987	3.7	3.5	6.6	7.3

[1] CPI index for all urban consumers, unadjusted figures.

Source: U.S. Department of Labor, Bureau of Labor Statistics, Consumer Price Index.

TABLE 9.—PHYSICIANS' AVERAGE NET INCOME AFTER EXPENSES BUT BEFORE TAXES, SURVEY RESULTS, 1983–1986

	Average net income [1] (in thousands)				Percent change 1985–86
	1983	1984	1985	1986	
All physicians [2]	$106.3	$108.4	$113.2	$119.5	6.5
Specialty:					
General/family practice	68.5	71.1	77.9	80.3	3.1
Internal medicine	93.3	103.2	101.0	109.4	+8.3
Surgery	145.5	151.8	155.4	162.4	4.5
Pediatrics	70.7	74.5	77.1	81.8	6.1
Obstetrics/gynecology	119.9	116.2	122.7	135.9	10.8
Radiology	148.0	139.8	150.8	168.8	11.9
Psychiatry	80.0	85.5	88.6	91.5	3.3
Anesthesiology	144.7	145.4	140.2	150.2	7.1
Census Division:					
New England	84.5	87.3	108.3	107.1	−1.1
Middle Atlantic	98.6	98.4	107.9	114.6	6.2
East North Central	114.3	109.4	118.9	126.6	6.5
West North Central	110.5	110.7	113.7	120.7	6.2
South Atlantic	106.7	114.5	112.6	119.6	6.2
East South Central	114.9	122.2	115.0	122.6	6.6
West South Central	124.4	119.1	123.3	129.0	4.6
Mountain	91.4	102.3	97.5	108.5	11.3
Pacific	103.1	109.4	113.6	119.0	4.8
Location:					
Nonmetropolitan	87.2	90.9	94.2	107.7	14.3
Metropolitan:					
Less than 1,000,000	111.0	115.1	118.1	124.5	5.4
1,000,000 and over	106.3	106.4	112.8	117.5	4.2
Employment Status:					
Self-employed	115.9	118.6	124.5	131.1	5.3
Employee	77.6	80.4	83.8	91.7	9.4

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[1] Average net income after expenses but before taxes. These figures include contributions made into pension, profit-sharing, and deferred compensation plans.

[2] Includes physicians in specialties not reported separately.

Source: Socioeconomic Characteristics of Medical Practice, 1987, American Medical Association.

TABLE 10.—NET PRACTICE EARNINGS OF PHYSICIANS NATIONWIDE FROM 16 SPECIALTIES, SURVEY RESULTS, 1981

	Commercial plans		Blue Shield		Medicare		Medicaid	
	Amount per capita	As percent of gross	Amount per capita	As percent of gross	Amount per capita	As percent of gross	Amount per capita	As percent of gross
Anesthesiologists	$40,880	27	$43,750	29	$32,790	22	$12,970	10
Family practitioners	25,110	17	18,390	13	21,220	15	12,370	9
General practitioners	22,620	17	16,800	13	21,170	18	12,250	10
General surgeons	47,700	26	45,570	27	43,750	25	13,190	8
Internists	20,870	15	26,420	19	39,630	29	8,740	7
Neurologists	34,070	22	32,860	22	37,390	24	12,040	9
Neurosurgeons	67,040	32	57,220	28	37,310	18	14,920	8
Obstetricians/gynecologists	59,690	32	55,070	30	8,530	5	15,450	8
Ophthalmologists	18,900	10	21,610	11	49,010	24	12,770	8
Orthopedic surgeons	76,920	31	58,050	25	43,220	17	14,390	6
Pathologists	18,420	14	34,850	26	28,000	21	13,330	11
Pediatricians	16,750	14	12,080	12	1,170	1	10,950	9
Plastic surgeons	43,870	25	34,670	22	18,780	12	8,710	5
Psychiatrists	25,370	24	20,140	19	6,370	6	5,340	5
Radiologists	32,840	18	51,420	28	49,730	28	18,450	11
Thoracic surgeons	43,110	21	57,990	26	72,420	35	15,930	7
All surgical specialists	50,950	26	48,010	25	38,910	20	13,540	8
All non-surgical specialists	25,710	19	27,430	20	24,660	17	10,710	8
All M.D.'s	33,480	21	32,030	20	27,490	17	11,440	8

Source: Medical Economics Continuing Survey, 1982, as reported in Owens, Arthur. "How Much of Your Income Comes From Third Parties?" Medical Economics, April 4, 1983.

SUPPLY OF HOSPITAL BEDS AND PHYSICIANS

The national supply of community hospital beds per 1,000 population has steadily increased since the 1940's, reaching a peak of 4.6 beds per 1,000 population in 1975. By 1984, the number of beds had dropped to 4.3 per 1,000 populations. Similar trends can be seen in the nine census regions, except for New England, which has seen a reduction since 1940 from 4.4 beds to 4.1 beds per 1,000 population in 1984, and the Pacific region, where the reduction has been from 4.1 beds in 1940 to 3.2 beds in 1984. The area experiencing the largest increase has been the East South Central, where beds increased from 1.7 per 1,000 population in 1940 to 5.1 in 1984. (see table 11).

TABLE 11.—HOSPITAL BEDS PER 1,000 POPULATION,[1] ACCORDING TO GEOGRAPHIC DIVISION: UNITED STATES, SELECTED YEARS 1940–84

[Data are based on reporting by facilities]

Geographic division	Year						
	1940 [2]	1950 [2]	1960 [3]	1970	1975	1980	1984
United States	3.2	3.3	3.6	4.3	4.6	4.5	4.3
New England	4.4	4.2	3.9	4.1	4.2	4.1	4.1
Middle Atlantic	3.9	3.8	4.0	4.4	4.6	4.6	4.5
East North Central	3.2	3.2	3.6	4.4	4.7	4.7	4.6
West North Central	3.1	3.7	4.3	5.7	5.8	5.8	5.6
South Atlantic	2.5	2.8	3.3	4.0	4.3	4.5	4.3
East South Central	1.7	2.1	3.0	4.4	4.9	5.1	5.1
West South Central	2.1	2.7	3.3	4.3	4.7	4.7	4.4
Mountain	3.6	3.8	3.5	4.3	4.0	3.8	3.6
Pacific	4.1	3.2	3.1	3.7	3.9	3.5	3.2

[1] Civilian population.

[2] 1940 and 1950 data are estimated based on published figures.

[3] 1960 includes hospital units of institutions.

Note: Hospitals include all non-Federal short-stay hospitals classified by the American Hospital Association according to one of the following services: general medical and surgical; obstetrics and gynecology; eye, ear, nose, and throat, rehabilitation; orthopedic; other specialty; children's general; children's eye, ear, nose, and throat; children's rehabilitation; children's orthopedic; and children's other specialty.

Source: Health, United States, 1984. U.S. Department of Health and Human Services. DHHS Publication No. (PHS) 85-1232, Table 66, pp. 127–128. Data for 1984 from the National Center for Health Statistics, unpublished data.

The number of active physicians in the country has increased from 279,212 in 1970 to 552,716 in 1985. This growth rate exceeded the rate at which the population of the Nation grew during the decade.

As table 12 below indicates, the ratio of physicians-to-population increased from 137 physicians per 100,000 population in 1970 to 225 physicians per 100,000 population in 1986. This table also indicates variations in the supply of physicians relative to population by State. In 1986, the District of Columbia had the highest ratio (617 physicians per 100,000 population) while Mississippi had the lowest ratio (131 physicians per 100,000 population).

TABLE 12.—NON-FEDERAL PHYSICIAN/POPULATION RATIOS AND RANK BY STATE

[Ratios: Non-Federal physicians (M.D.'s) per 100,000 civilan population]

Geographic area	1970	1975 [1]	1986	1986 rank
United States [2]	137	156	225	....
Alabama	84	100	157	43
Alaska	65	92	142	48
Arizona	123	151	222	15
Arkansas	85	95	155	44

TABLE 12.—NON-FEDERAL PHYSICIAN/POPULATION RATIOS AND RANK BY STATE—Continued

[Ratios: Non-Federal physicians (M.D.'s) per 100,000 civilan population]

Geographic area	1970	1975 [1]	1986	1986 rank
California	175	196	267	7
Colorado	163	172	218	18
Connecticut	178	207	310	5
Delaware	124	138	205	21
District of Columbia	365	436	617	1
Florida	124	155	241	11
Georgia	100	119	174	36
Hawaii	138	160	250	9
Idaho	87	95	135	50
Illinois	130	156	222	15
Indiana	96	109	159	41
Iowa	97	105	154	45
Kansas	108	128	183	32
Kentucky	96	117	167	39
Louisiana	114	127	189	28
Maine	98	122	198	23
Maryland	171	206	340	2
Massachusetts	194	222	340	2
Michigan	117	135	192	27
Minnesota	142	162	226	14
Mississippi	78	87	131	51
Missouri	120	141	198	23
Montana	97	111	162	42
Nebraska	106	124	174	37
Nevada	102	117	176	34
New Hampshire	125	146	210	20
New Jersey	136	162	249	10
New Mexico	103	121	187	31
New York	223	235	326	4
North Carolina	103	124	189	28
North Dakota	88	104	170	38
Ohio	125	137	202	22
Oklahoma	94	108	153	46
Oregon	133	160	218	18
Pennsylvania	143	158	240	12
Rhode Island	143	175	257	8
South Carolina	85	106	167	39
South Dakota	76	83	143	47
Tennessee	113	134	194	25

TABLE 12.—NON-FEDERAL PHYSICIAN/POPULATION RATIOS AND RANK BY STATE—Continued

[Ratios: Non-Federal physicians (M.D.'s) per 100,000 civilan population]

Geographic area	1970	1975 [1]	1986	1986 rank
Texas	109	129	177	33
Utah	129	150	189	28
Vermont	169	189	272	6
Virginia	113	136	219	17
Washington	136	154	229	13
West Virginia	98	120	176	34
Wisconsin	113	129	193	26
Wyoming	91	100	140	49

[1] Numbers of active non-Federal physicians are adjusted for 1975 to include about 90 percent of those not classified as to status or activity by the American Medical Association.

[2] Excludes counts of physicians in U.S. possessions and with unknown addresses.

Source: American Medical Association, Physician Characteristics and Distribution in the United States 1987 edition. Table A–9, p. 34.

The number of physicians in the United States is expected to continue to grow at a faster rate than the general population. The Department of Health and Human Services estimated that there were 221 active physicians per 100,000 population in 1985. They project ratios of 238 in 1990, 252 in 1995, and 264 in 2000.

HEALTH INSURANCE COVERAGE OF THE NONELDERLY POPULATION

According to the Census Bureau's Survey of Income and Program Population (SIPP), 85 percent of the U.S. population under age 65 were covered by some form of health insurance coverage during the last quarter of 1985 (see table 13). Most of this population (76.6 percent) were covered by private health insurance. Private health insurance is usually obtained under a group health plan at an individual's place of employment. Over 66 percent of the under age 65 population had employer-sponsored coverage at the end of 1985. Despite the prevalence of health insurance coverage, the SIPP data indicate that 31 million Americans or nearly 15 percent of the under 65 population were not covered by any form of health insurance coverage. Other surveys have shown that individuals from certain groups—low income, racial and ethnic minorities, and the unemployed—are more likely to lack health coverage.

TABLE 13.—HEALTH INSURANCE COVERAGE, FOURTH QUARTER—1985

[Numbers in thousands]

	Population	Percent covered by insurance	Number not covered	Percent not covered	Percent distribution of uncovered population
Total	235,520	86.7	31,285	13.3	100.0
Age:					
Less than 16	55,612	84.5	8,616	15.5	27.5
16 to 24	34,596	78.6	7,389	21.4	23.6
25 to 34	41,363	83.6	6,786	16.4	21.7
35 to 44	32,133	89.1	3,514	10.9	11.2
45 to 54	22,459	90.0	2,273	10.1	7.3
55 to 64	22,135	88.5	2,553	11.5	8.2
Total under 65	208,298	85.1	31,131	14.9	99.5
65 and over	27,222	99.4	154	.6	.5
Race:					
White	200,083	87.6	24,840	12.4	79.4
Black	28,496	80.7	5,501	19.3	17.6
Spanish origin [1]	14,175	73.0	3,822	27.0	12.2

[1] Persons of Spanish origin may be of any race.

Note: Numbers do not add due to rounding.

Source: "Disability, Functional Limitation, and Health Insurance Coverage: 1984/85;" Series P–70, No. 8, Table 10, Current Population Reports—Bureau of the Census.

A slightly higher estimate of the number uninsured can be obtained from the Current Population Survey. As table 14 indicates, the number of nonelderly individuals uninsured in 1987 was 37.1 million or 17.6 percent of the nonelderly population. Table 14 also illustrates that the number of individuals without health insurance has increased by 7.5 million from 1980 to 1987.

TABLE 14.—NONELDERLY POPULATION WITHOUT HEALTH INSURANCE, 1980–87

Year	Nonelderly population in millions	Nonelderly uninsured in millions	Percent uninsured
1980	199.0	29.6	14.9
1981	200.6	NA	NA
1982	202.1	30.7	15.2
1983	203.9	32.7	16.0
1984	205.6	35.0	17.0
1985	207.2	36.8	17.8
1986	209.4	36.9	17.6
1987	211.0	37.1	17.6

NA: Not available.

Source: Congressional Budget Office Tabulations of Current Population Surveys, March 1980–March 1987.

RELATIONSHIP OF MEDICAID COVERAGE TO POVERTY OF CHILDREN

SHARE OF POOR CHILDREN COVERED

Roughly one-half of all poor children (defined as children under 18 whose family income is below the poverty threshold) are covered by Medicaid (see table 15). One reason that this proportion is not larger is that automatic Medicaid eligibility is generally linked to the receipt of AFDC cash assistance. This has restricted Medicaid coverage in part because AFDC assistance is available only to families where one parent is absent; incapacitated; or in certain States, unemployed. To receive AFDC, a family must also meet a certain cash assistance standard established by each State. In all States except for Alaska, AFDC cash standards are below the Federal poverty threshold (estimated nation-wide for 1984 at $8,280 a year for a family of three). Therefore, many low-income families are not automatically eligible for Medicaid, though some may be able to obtain coverage under a State's medically needy program. Further, Medicaid eligibility requirements can vary widely among the States and families can often go on and off the AFDC (and therefore Medicaid) rolls during the course of a year.

TRENDS IN COVERAGE BY POVERTY STATUS

The percentage of poor children covered by Medicaid has been relatively consistent over time. In fact, the 1979 and 1983 percentages are identical—48.5 percent. This figure has not varied by more than 2 percentage points over the 8-year span (see table 15).

TABLE 15.—CHILDREN IN POVERTY AND MEDICAID COVERAGE, ALL CHILDREN UNDER 18

[Numbers in thousands]

Year	All poor children		
	Poor children	Covered by Medicaid	Percent
1979	10,111	4,907	48.5
1980	11,764	5,525	47.0
1981	12,505	5,811	46.5
1982	13,647	6,429	47.1
1983	13,807	6,693	48.5
1984	13,419	6,622	49.3
1985	13,010	6,569	50.5
1986	12,876	6,676	51.7

Note: This table is based on data obtained annually from the Current Population Survey (CPS) conducted by the Bureau of the Census and from supplementary surveys. Since the CPS estimates are based on a sample, they may differ somewhat from figures that would have been obtained if a complete census had been taken. The CPS data also are lower than program data from the Health Care Financing Administration (HCFA) because recipients tend to underreport their benefits in these surveys. Further, the CPS totals do not include children in institutions and may not include "Ribicoff children."

Source: March Current Population Survey (CPS) 1980–1987. Table prepared by CRS.

APPENDIX D. MEDICARE REIMBURSEMENT TO HOSPITALS [1]

Before the passage of the Social Security Amendments of 1983 (P.L. 98-21) the Medicare program reimbursed hospitals according to the reasonable costs they incurred in providing services to Medicare beneficiaries. Because the actual reasonable costs could not be determined until after the hospital had provided the services and reported its costs to the Medicare program, this method of reimbursement was known as retrospective cost-based reimbursement.

Under authority provided by the Social Security Amendments of 1972 (P.L. 92-603), the Department of Health and Human Services (HHS) placed certain limits on inpatient routine operating costs recognized as reasonable (referred to as section 223 limits for the specific section in the law). The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248, commonly referred to as TEFRA) expanded previously existing limits to include all other inpatient hospital operating costs. Further, it established a new 3-year Medicare ceiling (or target rate) on the allowable annual rate of increase in operating costs per case for inpatient hospital services. TEFRA also required that HHS develop proposals for the prospective payment of hospitals under Medicare. The proposal from HHS was presented to the Congress at the end of 1982.

Legislation based on this prospective payment proposal was enacted in Public Law 98-21, which established a new method of Medicare reimbursement for hospital inpatient care—the prospective payment system (PPS). This appendix describes the major reimbursement provisions of PPS.

GENERAL SUMMARY

Effective for hospital cost reporting periods that began on or after October 1, 1983, Medicare payment for hospital inpatient services is made according to a prospective payment system, rather than a retrospective cost-based system. Medicare payments are made at predetermined, specific rates which represent the average cost, nationwide, of treating a Medicare patient according to his or her medical condition. The classification system used to group hospital inpatients according to their diagnoses is known as diagnosis-related groups (DRGs). Separate DRG rates apply depending on whether a hospital is located in an urban or rural area of the country, as determined by the Office of Management and Budget (OMB) Metropolitan Statistical Area system.

During a 4-year transition period, a declining portion of the total prospective payment was based on a hospital's historical reasonable costs and an increasing portion was based on a combination of regional and national Federal DRG rates. In the fifth year of the program (fiscal year 1988) and thereafter, Medicare payments are generally determined under a national DRG payment methodology. Special transition provisions apply to hospitals located in Oregon and in certain geographic regions.

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[1] This appendix draws heavily from a Congressional Research Service issue brief entitled: "Medicare: Prospective Payments for Inpatient Hospital Services."

If a hospital can treat a patient for less than the payment amount, it can keep the savings. If the treatment costs more, the hospital must absorb the loss. A hospital is prohibited from charging Medicare beneficiaries any amounts (except for deductibles, copayment amounts, and for services not covered by Medicare) which represent any difference between the hospital's cost of providing covered care and the Medicare DRG payment amount.

Certain hospital costs are excluded from the prospective payment system and are paid on a reasonable cost basis. In addition, certain hospitals are excluded from the new system and continue to be reimbursed on a reasonable cost basis, subject to rate of increase limits. Authority is provided for States to establish their own all-payer hospital payment systems if they meet certain Federal requirements.

PROSPECTIVE PAYMENT SYSTEM

Unless excluded from the prospective payment system, each Medicare participating hospital is paid a predetermined payment rate per discharge for each type of patient treated. Types of patients are defined by the diagnosis related groups patient classification system which assigns each hospital inpatient to one of 473 patient categories (DRGs) based on the diagnosis and the type of treatment received (medical or surgical).

The payment rate for each DRG is the product of two components: a base payment amount which applies for all DRGs, and a relative weighting factor for the particular DRG. The base payment amount is intended to represent the cost of a typical (average) Medicare inpatient case. The relative weighting factor represents the relative costliness of an average case in the particular DRG compared to the cost of the overall average Medicare case (i.e., relative to the base payment amount). When the DRG relative weights are each multiplied by the base payment amount, the result is a complete set of prices for all DRGs. Separate DRG rates apply to hospitals located in urban or rural areas of the country as determined by OMB's Metropolitan Statistical Area system (separate base payment amounts apply in these areas, but the DRG relative weighting factors are the same). Hospitals located in areas reclassified from urban to rural are allowed a 2-year transition to rural rates. In addition, the base payment amount (and, therefore, each DRG rate) is adjusted for area differences in hospital wage levels compared to the national average hospital wage level.

Transition period

Application of the DRG payment rates (urban and rural) was phased in over a 4-year transition period, starting with each hospital's first cost reporting period which began on or after October 1, 1983. During the transition period, each hospital's payment rates were determined by the hospital's base payment amount per discharge. This amount is a combination of: (1) a hospital specific amount based on the hospital's historical costs in a base year updated for inflation, and (2) a Federal payment amount. The Federal payment amount during the transition is also a combination of two amounts: (1) the national urban or rural payment amount; and (2) the regional urban or rural payment amount for the hospital's geographic region (regional urban and rural payment amounts are calculated separately for each of the nine census regions).

The transition works by gradually shifting the relative importance of each of these amounts in determining the hospital's base payment amount per discharge. Over the 4-year period, the share of the hospital's base payment amount that is based on the hospital specific amount and the Federal regional amount diminishes, and the share of the Federal national amount increases. (See table 1.) Changes in the percentage factors used to combine the hospital specific amount with the Federal amount generally occur at the beginning of each hospital's cost reporting period. Changes in the percentage factors used to combine the components of the Federal amount usually occur at the beginning of the Federal fiscal year.

During the first year of the program (fiscal year 1984), the hospital's base payment amount was determined as 75 percent of the hospital specific amount plus 25 percent of the Federal amount (which was 100 percent regional). In the second year (fiscal year 1985), the hospital's base payment amount was equal to 50 percent of the hospital specific amount plus 50 percent of the Federal amount (which was 25 percent of the national amount plus 75 percent of the regional amount). In the third year (fiscal year 1986), the payment rates and the transition were frozen at fiscal year 1985 levels for the first 7 months of the year. Thus, the base amount during the first 7 months of the hospital's cost reporting period which began in that fiscal year was equal to 50 percent of the hospital specific amount plus 50 percent of the Federal amount (25 percent national and 75 percent regional). During the remaining 5 months of the hospital's cost reporting period, the base amount per discharge was equal to 45 percent of the hospital specific amount plus 55 percent of the Federal amount (25 percent national, 75 percent regional). In the fourth year (fiscal year 1987), the base amount was determined as 25 percent of the hospital specific amount plus 75 percent of the Federal amount (50 percent national and 50 percent regional). In the fifth year (fiscal year 1988), the payment amounts were frozen and scheduled changes in the transition percentages were delayed for the first 51 days of the fiscal year. Thus, until November 21, 1987, the hospital's base payment amount is equal to 25 percent of the hospital specific amount plus 75 percent of the Federal amount (50 percent regional and 50 percent national). For discharges occurring on or after November 21, 1987, the Federal amount is generally based on 100 percent of the national rate. The hospital specific amount continues to be combined with the Federal amount (25 percent hospital specific, 75 percent Federal) through the first 51 days of the hospital's cost reporting period which begins during fiscal year 1988. On the 52d day and thereafter, the base payment amount is generally determined using 100 percent of the national Federal amount. However, for discharges occurring on or after April 1, 1988, and before October 1, 1990, Public Law 100-203 provides that the Federal amount for hospitals located in each geographic region is determined as the higher of (1) 100 percent of the national amount or, (2) 85 percent of the national amount plus 15 percent of the regional amount. This provision is known as the "regional floor".

TABLE 1.—MEDICARE PROSPECTIVE PAYMENT SYSTEM TRANSITION SCHEDULE

Fiscal year [1]	Hospital specific portion (percent)	Federal DRG portion (percent)
1984	75	25 (0 national plus 100 regional).
1985	50	50 (25 national plus 75 regional).
1986 [2]	[3] 50	50 (25 national plus 75 regional).[3]
	[4] 45	55 (25 national plus 75 regional).[4]
1987 [2]	25	75 (50 national plus 50 regional).
1988 [2]	25	75 (50 national plus 50 regional).[5]
	0	100 (100 national plus 0 regional).[6]

[1] The hospital-specific portion and the Federal DRG portion change with the beginning of the hospital's fiscal year. The Federal (national and regional) rates and their proportional shares change with the beginning of the Federal fiscal year.

[2] Special payment rules apply to hospitals in Oregon.

[3] Effective during the first 7 months of a hospital's cost reporting period beginning on or after October 1, 1985.

[4] Effective during the remaining 5 months of a hospital's cost reporting period beginning on or after October 1, 1985.

[5] The percentages of the national and regional Federal amounts apply for discharges occurring during the first 51 days of the fiscal year. The percentages for combining the hospital specific and Federal amounts (25 and 75), apply for the first 51 days of the hospital's cost reporting period that begins during the fiscal year.

[6] The Federal amount is based on 100 percent of the national amount for all discharges occurring after November 21, 1987, but before April 1, 1988. For discharges occurring from April 1, 1988, to September 30, 1990, the Federal amount is the higher of 100 percent of the national amount, or 85 percent of the national amount plus 15 percent of the applicable regional amount. The percentages used to combine the hospital specific amount and the Federal amount apply for discharges occurring after the 51st day of the hospital's cost reporting period that begins during the fiscal year.

DRG payment levels and updating

The Federal payment amounts (urban and rural, regional and national), were derived from an average of historical (1981) Medicare cost data for each hospital. The amounts were updated through fiscal year 1983 by the estimated actual rate of increase in hospital costs nationally. By law, the amounts were increased for fiscal year 1984 by the estimated annual increase in a market basket index, representing the cost of goods and services purchased by hospitals, plus 1 percentage point. For fiscal year 1985, DEFRA provided that the rate of increase was the increase in the market basket, plus one-quarter of 1 percentage point. For fiscal years 1984 and 1985, the payment amounts were adjusted so that the total payments projected under the prospective system equaled the payments which would have been made under the reasonable cost reimbursement provisions of prior law as limited by the target rate of increase provisions established by TEFRA (this requirement is known as "budget neutrality").

Public Law 99-201 (the Emergency Extension Act of 1985) and Public Law 99-272 (COBRA) provided that the fiscal year 1986 PPS payment rates would be frozen at fiscal year 1985 levels until May 1, 1986, and would be increased one-half percent for the remainder of the fiscal year. Public Law 99-177 (the Balanced Budget and Emergency Deficit Control Act of 1985, known as Gramm-Rudman-Hollings) reduced fiscal year 1986 Medicare payments to hospitals by 1 percent beginning March 1, 1986.

For fiscal years 1987 and 1988, Public Law 99-272 provided that the Secretary could determine any change in the PPS payment rates, taking into account the recommendations of the Prospective Payment Assessment Commission, not to exceed the market basket index change. However, Public Law 99-509 replaced the Secretary's determination that the PPS rates for fiscal year 1987 would be increased by 0.5 percent, and provided that the rates would be increased by 1.15 percent in fiscal year 1987 and by the hospital market basket increase minus 2 percentage points in fiscal year 1988.

Public Law 100-119 (the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987) provides that PPS payments from October 1, 1987, through November 20, 1987, are frozen at fiscal year 1987 levels (the update is zero percent for this period). On November 21, 1987, the payment rates were increased, as required by Public Law 99-509, by the market basket increase minus 2 percentage points, or 2.7 percent. Also on November 21, 1987, the final sequester order pursuant to Public Law 100-119 required that all Medicare payments to hospitals be reduced by 2.324 percent. Public Law 100-203 (OBRA87) required that the sequestration reductions continue through March 31, 1988. Beginning on April 1, 1988, instead of the 2.7 percent update provided in OBRA86, the PPS payment rates are increased by 3 percent for hospitals located in a rural area, by 1.5 percent for hospitals located in an urban area with a total population of more than 1 million persons (large urban areas), and by 1 percent for hospitals located in other urban areas.

For fiscal year 1989, Public Law 100-203 requires the Secretary to increase the PPS payment rates by the market basket increase minus 1.5 percentage points for hospitals located in a rural area, by the market basket increase minus 2 percentage points for hospitals located in a large urban area, and by the market basket increase minus 2.5 percentage points for hospitals located in other urban areas.

The market basket is defined in table 2. This is a uniform index for all hospitals and yields one price inflator for all hospitals in a given year. The relative importance weights of the different categories of cost change periodically.

TABLE 2.—HOSPITAL PROSPECTIVE PAYMENT INPUT PRICE INDEX (THE "MARKET BASKET")

Expense categories	Relative importance [1]		Projected increase 1989 (percent)
	1986	1989	
1. Wages and Salaries [2]	57.29	56.49	5.1
2. Employee Benefits [2]	10.05	9.31	4.9
3. Professional Fees [2]	.78	.82	5.3
4. Energy and Utilities	2.25	2.11	5.5
a. Fuel, Oil, Coal, and Other Petroleum	.60	.56	6.8
b. Electricity	1.06	.99	4.5
c. Natural Gas	.35	.31	6.5
d. Motor Gasoline	.21	.21	5.5
e. Water and Sewage	.03	.04	6.9
5. Malpractice Insurance	1.19	1.76	19.4
6. All Other	28.44	29.52	NA
All Other Products	19.77	20.66	4.4
a. Pharmaceuticals	4.92	5.83	7.2
b. Food	3.29	3.36	4.3
(1) Contract Service	1.28	2.02	3.9
(2) Direct Purchase	2.01	1.34	4.8
c. Chemicals and Cleaning Products	2.42	2.43	1.6
d. Surgical and Medical Instruments	2.13	2.09	3.5
e. Photographic Supplies	2.08	2.07	3.6
f. Rubber and Plastics	1.86	1.82	3.2
g. Paper Products	1.09	1.11	3.9
h. Apparel	.92	.89	3.1
i. Minor Machinery Equipment	.39	.40	4.3
j. Miscellaneous Products	.67	.66	4.5
All Other Services	8.67	8.86	4.7
a. Business Services [2]	3.00	3.03	4.1
b. Computer and Data Processing Services [2]	1.53	1.65	6.6
c. Transportation and Shipping	.97	1.00	4.8
d. Telephone	.81	.78	3.2
e. Blood Services [2]	.47	.50	6.5
f. Postage [2]	.30	.28	1.4
g. All Other Services: Labor Intensive [2]	.97	.98	4.3
h. All Other Services: Nonlabor Intensive	.62	.64	4.8
Total	100.00	100.00	5.1

[1] These weights are used to develop the revised labor-related/nonlabor-related components of the standardized rates.

[2] Considered labor-related.

Source: 51 F.R. 31530, September 3, 1986 and Prospective Payment Assessment Commission.

Public Law 98-21 required the HHS Secretary to adjust the DRG definitions and weighting factors in fiscal year 1986 and at least every 4 years thereafter to reflect changes in treatment patterns, technology, and other factors which may change the relative use of hospital resources. Public Law 99-509, however, required the Secretary to adjust the DRG definitions and weighting factors each year, beginning in fiscal year 1988.

Table 3 provides historical data on recent trends in some of the factors related to increases in the PPS payment rates and increases in average payments per Medicare discharge. Trends in the general level of prices of goods services as measured by the GNP deflator are also shown for comparison.

The annual update factor applied to increase the Federal base payment amounts for the forthcoming year is determined, in part, by the projected rate of increase in the hospital market basket index. The update factor also includes adjustments for increases in hospital productivity, technological change, changes in practice patterns (e.g., the decline in length of stay) and other factors that are expected to affect the level of operating cost per discharge. It is also adjusted to offset that part of the historical increase in average payments per case that is attributable to increases in reported case mix due to changes in coding and reporting accuracy.

Note, however, that the actual increase in the PPS payment rates (the DRG prices) has differed from the update factor each year for several reasons. For example, in the first 2 years, (fiscal years 1984 and 1985) the PPS payment rates were required to be adjusted so that aggregate payments to hospitals included in PPS would be equal to the aggregate payments they would have received if they had been paid under the provisions of prior law (the target rate of increase limits established in TEFRA, Public Law 97-248). As a result of the budget neutrality adjustment, the actual increases in the DRG prices were lower than the increases provided by the PPS update factors for those years, which were set at the market basket increase plus 1 percentage point (5.9 percent) in fiscal year 1984, and the market basket increase plus one-quarter of 1 percentage point (4.4 percent) in fiscal year 1985. In fiscal year 1986, the PPS rates were frozen by the Congress and the update factor of 0.5 percent established in COBRA (Public Law 99-272) applied for only the last 5 months of the fiscal year. Actual increases in the DRG rates in each year also have been affected by changes in policy that required recalculation or adjustment of the Federal base payment amounts or the DRG relative weights.

Actual annual increases in average payments per case depend on a variety of factors in addition to the increase in the PPS rates. Average payments per case include PPS operating payments (DRG payments), payments for the indirect costs of medical education programs, payments for direct medical education costs, payments for capital-related costs and other passthrough payments (kidney acquisition costs, etc.) and payments to hospitals and units excluded from PPS. Therefore, annual increases in average payments per case depend on the increase in the PPS payment rates (which may be larger or smaller than the update factor), the increase in reported case mix and the increases in payments for medical education, capital costs, and payments to excluded hospitals and units. In addition, the increase in actual average payments per case is influenced by changes in other policies. For example, the phaseout of payments for a return on equity capital for proprietary providers will reduce the increase in average payments per case. Similarly, policy changes that increase the number of cases in which the Medicare program is the secondary payer also reduce the increase in the average payment per case. Thus, average payments per discharge may be influenced by factors unrelated to PPS payment policy.

TABLE 3.—HISTORICAL TRENDS IN FACTORS AFFECTING THE PPS RATES AND AVERAGE PAYMENTS PER CASE

[Percentage change from the previous year]

	Fiscal year:							
	1982	1983	1984	1985	1986	1987	1988 [1]	1989 [1]
Market basket index	8.3	5.9	4.9	4.1	3.1	4.5	4.7	[2] 4.6
Annual update factor			[3] 5.9	[3] 4.4	[4] 0.5	1.15	[5] 1.6	[6] 2.6
Case mix index			8.4	2.5	2.7	2.4	1.5	0.5
Average payments per case	14.0	10.4	10.4	14.9	7.1	4.1	2.0	3.0
Average payments per beneficiary	15.4	11.7	7.2	6.3	2.9	1.8	1.6	4.1
GNP deflator	6.4	3.8	3.9	3.4	2.9	3.0	3.5	4.0

[1] Percent change in case mix and payments per case and per beneficiary are projected based on economic assumptions in the President's budget for fiscal year 1989.

[2] Projection included in the President's budget for fiscal year 1989.

[3] The update factor for this year was offset by adjustments including the budget neutrality adjustment.

[4] Effective beginning with the eighth month of the fiscal year.

[5] This figure is a weighted average of the separate update factors for rural, large urban, other urban and excluded hospitals and units, that take effect on April 1, 1988.

[6] This figure is a weighted average of the separate updates applicable under current law given the OMB projection for the market basket increase in fiscal year 1989.

Source: Preliminary data from the Health Care Financing Administration, except the GNP deflators for fiscal years 1987–89, which are from CBO.

It is also important to note that the expenses incurred by hospitals in serving Medicare patients are rising faster that the increase in the hospital market basket. The market basket index measures the increase in the prices of the goods and services purchased by hospitals. The expenses hospitals incur are affected by changes in volume, by the introduction of new technology, and by decisions made by physicians and hospital managers to increase the amount of resources provided to patients. Table 4 illustrates this trend.

TABLE 4.—CHANGE IN AGGREGATE MEDICARE OPERATING COSTS, CASES, AND COSTS PER CASE FROM PPS1–PPS3 (PERCENT CHANGE)

Hospital type	PPS1 to PPS2			PPS2 to PPS3			Average		
	Costs	Cases	Costs per case	Costs	Cases	Costs per case	Costs	Cases	Costs per case
All hospitals	2.5	−6.8	10.0	6.5	−3.6	10.4	4.5	−5.2	10.2
Urban	3.5	−6.0	10.2	6.7	−2.8	9.8	5.1	−4.4	10.0
Rural	−1.5	−8.7	7.9	5.6	−5.6	11.8	2.0	−7.1	9.8
Sole community hospitals	−2.5	−10.1	8.4	1.7	−5.0	7.0	−.4	−7.6	7.7
Rural less than 50 beds	−3.9	−11.4	8.5	.4	−8.6	9.8	−1.7	−10.0	9.2

Source: Preliminary ProPAC estimates based on Medicare Cost Report data from the first 3 years of PPS for 2,233 hospitals. Excludes hospitals in Maryland, Massachusetts, New Jersey, and New York. PPS1 is the first year of PPS.

Additional payment amounts

In addition to the DRG prospective payment rates, Medicare payments are made to hospitals for the following items or services:

Outliers

Additional amounts are paid to hospitals for atypical cases (known as "outliers") which have either extremely long lengths of stay (day outliers) or extraordinarily high costs (cost outliers) compared to most discharges classified in the same DRG. The law requires that total outlier payments to hospitals covered by the system represent no less than 5 percent and no more than 6 percent of the total estimated Medicare DRG payments for the fiscal year. Effective with discharges occurring on or after October 1, 1984, a transferring hospital may qualify for an additional payment for extraordinarily high-cost cases meeting the criteria for cost outliers. Outlier payments are financed by an offsetting overall reduction in the Federal portion of the base payment amount per discharge. Effective October 1, 1986, Public Law 99-509 established separate urban and rural set-aside factors for financing outlier payments.

Public Law 100-203 increased payments for outlier cases classified in DRGs relating to patients with burns from April 1, 1988, through September 30, 1989. This legislation also prohibited the Secretary from issuing any final regulations before September 1, 1988, which change the method of payment for outlier cases (other than burn cases).

To determine the amount of additional payments for outlier cases, the length of stay (LOS) for each case in a DRG is first compared against the applicable LOS threshold for the category. If the LOS for a case exceeds the threshold, then the case qualifies as a day outlier. In this instance, the hospital is paid its regular payment rate per discharge (for this DRG), plus the Federal portion of a per diem amount (60 percent of the hospital's Federal per diem rate for the DRG) for each Medicare covered day above the LOS threshold.

If the case does *not* qualify as a day outlier, then it may qualify as a cost outlier. The case will qualify for extra payments on this basis if the hospital's Medicare covered charges for the case, adjusted to operating costs (and reduced by its indirect teaching and disportionate share adjustments, if applicable), exceed its cost outlier threshold for the DRG. In this instance, the hospital is paid its regular payment rate per discharge for the DRG, plus the Federal portion of 60 percent of the difference between its adjusted (and reduced) charges for the case and the cost outlier threshold.

Table 5 shows the changes in outlier policy that have occurred during the first 5 years of the PPS. Table 6 presents summary statistics (estimated) for fiscal year 1988 and table 7 shows the distribution of outlier payments across hospitals.

TABLE 5.—FISCAL YEAR 1984–1988 OUTLIER POLICY PARAMETERS

	1984	1985	1986 [1]	1987	1988
Pool target	5.7% (1.4%) [2]	5.0%	5.0%	5.4% (urban) 2.2% (rural)	5.6% (urban) 2.5% (rural)
Federal portion	25.0% [2]	50.0%	55.0%	75.0%	100.0%
Length of stay thresholds [3].	Lesser of 20 days or 1.94 x S.D.	Lesser of 22 days or 1.94 x S.D.	Lesser of 17 days or 1.94 x S.D.	Lesser of 17 days or 1.94 x S.D.	Lesser of 18 days or 2.00 x S.D.
Cost thresholds	Greater of 1.5 x DRG Federal rate or $12,000	Greater of 2.0 x DRG Federal rate or $13,000	Greater of 2.0 x DRG Federal rate or $13,500	Greater of 2.0 x DRG Federal Rate or $13,500	Greater of 2.0 x DRG Federal rate or $14,000
Cost-to-charge ratio used for cost outliers.	72.0%	72.0%	72.0%	66.0%	66.0%
Marginal cost factor	60.0%	60.0%	60.0%	60.0%	60.0%

[1] The outlier policy for fiscal year 1986 was effective May 1, 1986.

[2] For PPS discharges between October 1, 1983 and February 2, 1984, outlier payments were anticipated to be approximately 5.7 percent of total basic PPS payments. Outlier payments applied to both the hospital-specific and the Federal portion of the payment during that period. For PPS discharges between February 3, 1984 and September 20, 1984, outlier payments were anticipated to be approximately 1.4 percent of total anticipated PPS payments (25 percent of 5.7 percent). After February 2, 1984, hospitals only received outlier payments on the Federal portion of their prospective payment.

[3] The LOS threshold for a DRG is set at the lesser of the national average LOS for all cases in the DRG plus a fixed number of days (e.g., 20 days in fiscal year 1984) or the national average LOS for the DRG plus a fixed number of standard deviations (e.g., 1.94 SD in fiscal year 1984). The number of days represented by a fixed number of standard deviations varies among the DRG categories.

Source: ProPAC.

TABLE 6.—SUMMARY STATISTICS BY OUTLIER TYPE

	All	Cost	Day-only [1]	Dual [2]
Percent of PPS cases	3.6	0.5	2.2	0.9
Mean charge	$26,620	$34,790	$25,290	$48,220
Mean cost	$18,250	$19,220	$18,090	$30,880
Average total payment [3]	$11,130	$9,670	$11,370	$16,480
Average outlier payment	$5,480	$3,110	$4,160	$9,860
Average loss	−$7,120	−$9,550	−$6,720	−$14,400
Mean LOS	36	20	38	49
Mean special care days	6	10	5	12

[1] The current law definition of length of stay outliers includes both day-only and dual outliers (those cases that qualify as both day and cost outliers).

[2] Dual outliers are paid as day outliers.

[3] Represents the average total payment for outlier cases, including the regular DRG payment.

Source: ProPAC estimates derived by applying fiscal year 1988 payments rules to the fiscal year 1986 MEDPAR data.

TABLE 7.—OUTLIER PAYMENTS AS A PERCENTAGE OF TOTAL PPS PAYMENTS

Hospital group	Total	Cost	Day-only	Dual
Total	5.7	0.5	2.6	2.6
New England	9.0	.1	5.5	3.4
Middle Atlantic	11.0	.2	6.8	4.1
South Atlantic	5.8	.7	1.9	3.2
East North Central	4.3	.3	1.7	2.4
East South Central	4.2	.6	1.5	2.2
West North Central	3.3	.4	1.3	1.7
West South Central	3.5	.6	1.1	1.8
Mountain	3.2	.8	.7	1.7
Pacific	3.7	.7	1.1	1.9
Rural	3.5	.5	1.6	1.4
Urban	6.1	.5	2.8	2.8
Less than 100 beds	3.4	.6	1.7	1.1
100 to 249 beds	5.1	.6	2.2	2.2
250 to 404 beds	5.7	.4	2.5	2.8
405 to 684 beds	6.9	.4	3.2	3.3
685 beds or more	8.7	.2	4.4	4.1
Rural	3.5	.5	1.6	1.4
Less than 50 beds	1.3	.1	.8	.3
50 to 99 beds	2.0	.4	.9	.7
100 to 169 beds	2.9	.5	1.3	1.1
170 beds or more	6.1	.5	2.7	2.8
Nonteaching	4.3	.6	1.9	1.9
Minor teaching	6.5	.3	3.1	3.1
Major teaching	8.8	.2	4.5	4.1
Disproportionate share:				
Urban MSA greater than 1 million	8.3	.4	3.9	3.9
Other urban	6.5	.4	3.5	2.6
Rural	8.3	2.2	3.0	3.0

TABLE 7.—OUTLIER PAYMENTS AS A PERCENTAGE OF TOTAL PPS PAYMENTS—Continued

Hospital group	Total	Cost	Day-only	Dual
Nondisproportionate share	4.7	.5	2.0	2.2
Urban MSA greater than 1 million	6.6	.5	3.0	3.2
Other urban	5.5	.4	2.6	2.4
Sole community provider	.5	.1	.2	.2
Rural referral center	3.8	.3	1.5	1.9
Sole community provider and rural referral center	.7	.1	.2	.4
Other rural	3.7	.6	1.8	1.4
Voluntary	5.8	.3	2.8	2.7
Proprietary	5.3	1.6	1.3	2.4
Urban government	5.8	.3	2.8	2.7
Rural government	3.5	.4	1.7	1.4

Source: ProPAC estimates derived by applying fiscal year 1988 payment rules to the fiscal year 1986 MEDPAR data.

Indirect medical education costs

Additional payments are made to hospitals under the prospective system for the indirect costs attributable to approved medical education programs. These indirect costs may be due to a variety of factors, including the extra demands placed on the hospital staff as a result of the teaching activity or additional tests and procedures that may be ordered by residents. Congressional reports on the PPS authorizing legislation indicate that the indirect medical education payments are also to account for factors not necessarily related to medical education which may increase costs in teaching hospitals, such as more severely ill patients, increased use of diagnostic testing, and higher staff-to-patient ratios.

As amended by Public Law 99-272, the additional payment to a hospital is based on a formula that provides an increase of approximately 8.1 percent in the Federal portion of the DRG payment, from May 1, 1986, to October 1, 1989. The payment increases with the ratio of a hospital's interns and residents to its bed size on a curvilinear or variable basis (i.e., the increase in the payment is less than proportional to the increase in the ratio of interns and residents to bed size).

Public Law 100-203 reduced the indirect medical education adjustment factor from approximately 8.1 percent to approximately 7.7 percent, effective for discharges occurring on or after October 1, 1988, but before October 1, 1990. The payment adjustment after October 1, 1990, when the disproportionate share adjustment expires, would be an increase of approximately 8.3 percent.

Disproportionate share hospitals

Public Law 99-272 provided that additional payments will be made from May 1, 1986, to October 1, 1988, to hospitals that serve a disproportionate share of low-income patients. For urban PPS hospitals with more than 100 beds having a percentage of low-income patients of at least 15 percent, the Federal portion of the hospital's PPS payment is increased by 2.5 percent plus one-half the difference between 15 percent and the hospital's percentage of low-income patients, not to exceed a 15 percent adjustment. For urban hospitals with less than 100 beds having a percentage of low-income patients of at least 40 percent, the payment increase is 5 percent. For rural hospitals having a low-income patient percentage of at least 45 percent, the payment increase is 4 percent.

The percentage of low-income patients is defined as the hospital's total number of inpatient days attributable to Medicare beneficiaries who also receive Federal Supplemental Security Income payments divided by the total number of Medicare patient days, plus the number of Medicaid patient days divided by the total patient days.

Payments will also be made to urban hospitals with 100 or more beds which demonstrate that more than 30 percent of their net inpatient revenues are derived from State and local government payments for indigent care (excluding payments under Medicare and Medicaid).

Public Law 99-509 authorized the Secretary to establish a separate threshold percentage of low-income patients required for rural hospitals of 500 or more beds to qualify for disproportionate share payments. The Secretary decided to make additional payments to such hospitals on the same basis as urban hospitals with more than 100 beds. The legislation also extended additional payments to disproportionate share hospitals through October 1, 1989, in a budget neutral fashion (i.e., the teaching adjustment factor used to make additional payments for the indirect costs of approved medical education programs continues to be reduced from 8.7 to 8.1 percent during fiscal years 1988 and 1989 to finance the disproportionate share payments).

Public Law 100-203 extended the additional payment for disproportionate share hospitals until October 1, 1990. Effective for discharges occurring on or after October 1, 1988, the upper limit on the disproportionate share adjustment percentage (currently 15 percent) for urban hospitals with 100 or more beds is eliminated. The disproportionate share adjustment percentage is also increased from 15 to 25 percent for urban hospitals with 100 or more beds which receive more than 30 percent of their net inpatient revenues (excluding revenues from Medicare and Medicaid) from State and local government contributions for indigent care. This legislation also authorized the Secretary to grant disproportionate share payments to certain hospitals that are part of a multifacility provider, if the individual hospital would qualify for disproportionate share payments but the provider as a whole does not.

Direct medical education costs

The direct costs of approved medical education programs (such as the salaries of residents and teachers and other education costs for residents, nurses, and allied health professionals) are excluded from the prospective payment system. The direct medical education costs for the training of nurses and allied health professionals are paid for on a reasonable cost basis.

Public Law 99-272 provided that payments for the cost of approved graduate medical education programs (i.e., residency training programs for physicians) be made as follows: For cost reporting periods beginning on or after July 1, 1985, the Medicare payment to each hospital is equal to the hospital's full-time equivalent (FTE) resident amount, times the weighted average number of FTE residents, times the percentage of inpatient days attributable to Medical Part A beneficiaries. For each hospital with an approved medical residency training program, an average cost per FTE resident is calculated using data from the hospital's cost reporting period that began in fiscal year 1984. These FTE amounts are updated by the increase in the CPI over the next 12-month period; for hospital cost reporting periods beginning July 1, 1985, the FTE resident amounts are increased by 1 percent; and for subsequent cost reporting periods, the FTE amounts are updated by the change in the CPI.

The number of FTE residents is calculated as follows; before July 1, 1986, the weighting factor for each FTE resident is 100 percent; after July 1, 1986, the weighting factor for residents in their initial residency period (i.e., within the minimum number of years of formal training necessary to satisfy specialty requirements for board eligibility plus 1 year, but not to exceed 5 years) is 100 percent; after July 1, 1986, but before July 1, 1987, the weighting factor for residents not in their initial residency period is 75 percent; after July 1, 1987, the weighting factor for residents not in their initial residency period is 50 percent. Geriatric residencies or fellowships not exceeding 2 years are excluded from these limits.

On or after July 1, 1986, residents who are foreign medical graduates (FMGs) will not be counted as FTE residents unless they have passed the Foreign Medical Graduate Examination in the Medical Sciences or have previously received certification from or have passed an examination of the Educational Commission for Foreign Medical Graduates. Those foreign medical graduates who were in training before July 1, 1986, and who are still residents will be counted at the 50 percent rate.

Public Law 99-509 provided that time spent in a nonhospital outpatient setting is reimbursable by Medicare if the hospital incurs substantially all of the costs of residency training in the ambulatory setting.

ESRD beneficiary discharges

Effective with cost reporting periods beginning on or after October 1, 1984, additional payments are made to hospitals for inpatient dialysis provided to end-stage renal disease (ESRD) beneficiaries if total discharges of such beneficiaries from non-ESRD related DRGs account for 10 percent or more of the hospital's total Medicare discharges. A hospital meeting the criteria is paid an additional payment for each ESRD beneficiary discharge based on the estimated weekly cost of dialysis and the average length of stay of its ESRD beneficiaries.

Payments on a reasonable cost basis

Costs for certain items are excluded from the prospective payment system and thus are not included in the prospective payment rates. Medicare pays for its share of the following costs according to the former reasonable cost-based system:

Capital-related costs.—Public Law 98-21 provided that capital-related costs (including depreciation, leases and rentals, interest, and a return on equity for proprietary hospitals) are excluded from the prospective payment system until no earlier than October 1, 1987, and are paid for on a reasonable cost basis. This legislation also required the Secretary to report to Congress within 18 months of enactment (October 1984) on methods and proposals by which capital costs can be included in the prospective payment rates. In March 1986, HHS submitted a report to Congress on incorporating capital costs in the prospective payment rates.

Public Law 99-272 provided that payments to proprietary hospitals for a return on equity (ROE) are separated from payments for other capital costs and phased out as follows: for hospital cost reporting periods beginning in fiscal year 1987, payment will equal 75 percent of the otherwise allowable ROE amount; for fiscal year 1988, 50 percent; for fiscal year 1989, 25 percent; and for fiscal year 1990 and thereafter, no ROE payments will be made.

Public Law 99-509 reduced payment amounts for capital-related costs by 3.5 percent for portions of cost-reporting periods in fiscal year 1987, 7 percent for fiscal year 1988, and 10 percent for fiscal year 1989. The legislation exempts sole community hospitals from capital-related payment reductions and regulations for 3 years. It also clarifies that the HHS Secretary may incorporate capital-related costs, on a budget neutral basis into PPS, effective October 1, 1987.

Public Law 100-119 (the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987) prohibited the Secretary from implementing published final regulations incorporating payments for capital costs into the DRG payment rates for fiscal year 1988, froze the capital payment reduction at the fiscal year 1987 level (3.5 percent), and delayed the phaseout of ROE payments to proprietary hospitals, for the period from October 1, to November 20, 1987. On November 21, 1987, the capital payment reduction reverted to the 7 percent level established for fiscal year 1988 in OBRA86, and the phaseout of ROE payments resumed.

OBRA87 increased the capital payment reduction to 12 percent for fiscal year 1988, effective on January 1, 1988, and 15 percent in fiscal year 1989. This legislation also prohibits the Secretary from incorporating payment of capital related costs into the PPS payment rates before October 1, 1991. However, the Secretary is required to make payments for capital related costs on a per case, prospective basis beginning on October 1, 1991. The methods to be used in making prospectively determined capital payments are generally left to the discretion of the Secretary. In addition, OBRA87 requires ProPAC to undertake a study and report to Congress by May 1, 1988, on the suitability and feasibility of linking payment for capital related costs to hospital occupancy rates.

Physicians in teaching hospitals.—If a teaching hospital so elects, the direct medical and surgical services of physicians in such hospitals will be excluded from the prospective payment system and paid for on the basis of reasonable costs.

Kidney acquisition costs.—The estimated net expenses associated with kidney acquisition in certified renal transplantation centers are excluded from the prospective payment system and paid on a reasonable cost basis.

Anesthesia services of hospital-employed nonphysician anesthetists.—Public Law 98–21 excluded the costs of anesthesia services provided by qualified nonphysician anesthetists or certified registered nurse anesthetists (CRNAs) employed by the hospital or obtained under contract, from the prospective payment system and provided for payments on the basis of reasonable costs for cost reporting periods beginning on or after October 1, 1984, and before October 1, 1987.

Public Law 99–509 extended current payment provisions for the services of hospital-employed CRNAs for cost reporting periods beginning before January 1, 1989. The legislation authorized direct reimbursement to a CRNA under Part B of Medicare for anesthesia services and related care which he or she is legally authorized to perform in the State where the services are provided. These payments would be made equal to the lower of 80 percent of actual charges or 80 percent of a fee schedule amount established by the Secretary. This provision is to be budget neutral. CRNAs would be required to accept Medicare's determination of the allowable amount (Medicare's payment plus the patient's 20 percent copayment amount) as payment-in-full for all Medicare services. The fee schedule would apply to services provided after October 1, 1989. Special limits on the actual charges of nonparticipating physicians for CRNA services and medical direction would apply.

Bad debts of Medicare beneficiaries

An additional payment is made to hospitals for bad debts attributable to unpaid deductible and copayment amounts related to covered services received by Medicare beneficiaries.

Public Law 100–203 prohibited the Secretary from making any change in the policy that was in effect on August 1, 1987, regarding payments to hospitals for bad debts of Medicare beneficiaries.

Calculation of Prospective Payment System payment amount

Hospital payment rates will change several times in fiscal year 1988 as different provisions of current law take effect. For the first 51 days of the year (from October 1, 1987, to November 20, 1987), the payment rates for hospitals under the PPS are frozen at the level for fiscal year 1987. During this period the base payment amount for each PPS hospital is equal to 25 percent of its hospital specific amount for the cost reporting period beginning in fiscal year 1987, plus 75 percent of the Federal amount (50 percent national, 50 percent regional) applicable in fiscal year 1988. The Federal amounts (both national and regional) for this period are the same as those shown in table 4, except they are reduced by 2.7 percent (in order to remove the 2.7 percent fiscal year 1988 update factor). For discharges occurring on or after November 21, 1987, the Federal amount is based on 100 percent of the national amount, and the national and regional amounts are increased by the update factor (2.7 percent) applicable for fiscal year 1988, as specified in Public Law 99–509 (OBRA86). Also, the 2.7 percent update to the hospital specific amount, and the shift to 100 percent national payment amounts, which otherwise would have taken effect with the beginning of each hospital's cost reporting period during fiscal year 1988, were delayed until the 52d day of the cost reporting period.

As a result, hospitals are paid in one of two ways after November 20, 1987. Some hospitals (with cost reporting periods that begin early in the fiscal year) will have passed the 52d day of their reporting period; these hospitals are paid DRG payment rates based entirely on the Federal national urban or rural base payment amount. For some part of the remainder of fiscal year 1988, however, most hospitals will be paid DRG payment rates calculated using a base payment amount which combines their hospital specific amount applicable for cost reporting periods beginning in fiscal year 1987 (25 percent), with a Federal payment amount based on 100 percent of the national urban or rural amount applicable for fiscal year 1988 (75 percent). During the course of fiscal year 1988, the transition provisions will expire for most of these hospitals and their DRG payment rates will shift to national urban or rural rates.

Note also that hospitals' DRG payment rates are scheduled to change again for discharges occurring on or after April 1, 1988, as the separate fiscal year 1988 updates for hospitals located in rural areas (3 percent), large urban areas (1.5 percent) and other urban areas (1 percent) replace the 2.7 percent update mandated by Public Law 99-509. Total payments to hospitals will increase at the same time because the sequestration reduction of 2.324 percent required by Public Law 100-119 (and extended by Public Law 100-203) expires on March 31, 1988.

The Federal urban and rural base payment amounts per discharge applicable between November 20, 1987, and April 1, 1988 (called adjusted standardized payment amounts), were published in the Federal Register on September 1, 1987 (see table 8). Although Federal urban and rural payment amounts are included for each region, after November 21, 1987, the regional amounts are applied in determining payment rates only for sole community hospitals and hospitals located in regions affected by the regional floor.

Each payment amount is divided into a labor-related component and a nonlabor related component. The sum of these components represents the base payment amount that would apply for a hospital located in an area with a wage index of 1.0 (i.e., average wage rates for hospital workers in the area match the national average of hospital wage rates across all areas).

TABLE 8.—AVERAGE ADJUSTED STANDARDIZED AMOUNTS BY CENSUS REGION, FISCAL YEAR 1988

[In dollars]

Region	Urban			Rural		
	Total	Labor-related	Nonlabor related	Total	Labor-related	Nonlabor related
1. New England (CT, ME, MA, NH, RI, VT).....	3,302.13	2,442.27	859.86	3,047.11	2,350.23	696.88
2. Middle Atlantic (PA, NJ, NY)........................	3,038.76	2,214.47	824.29	2,911.28	2,253.79	657.49

TABLE 8.—AVERAGE ADJUSTED STANDARDIZED AMOUNTS BY CENSUS REGION, FISCAL YEAR 1988—Continued

[In dollars]

Region	Urban			Rural		
	Total	Labor-related	Nonlabor related	Total	Labor-related	Nonlabor related
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	3,101.89	2,348.04	753.85	2,727.77	2,155.54	572.23
4. East North Central (IL, IN, MI, OH, WI)	3,369.24	2,477.09	892.15	2,815.59	2,180.78	634.81
5. East South Central (AL, KY, MS, TN)	2,939.73	2,255.07	684.66	2,669.75	2,136.28	533.47
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	3,158.73	2,346.62	812.11	2,642.07	2,072.68	569.39
7. West South Central (AR, LA, OK, TX)	3,109.89	2,356.52	753.37	2,514.98	1,990.81	524.17
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	3,049.90	2,248.43	801.47	2,629.38	2,022.89	606.49
9. Pacific (AK, CA, HI, OR, WA)	3,118.57	2,198.90	919.67	2,637.68	1,958.41	679.27
10. National	3,165.21	2,337.09	828.12	2,711.17	2,123.20	587.97

Source: 52 FR 33070, Sept. 1 1987.

Determination of the Federal DRG portion of the payment

For hospitals that have not yet reached the 52d day of their cost reporting period that begins in fiscal year 1988, DRG payment rates are determined using a base payment amount per discharge which combines a Federal portion (75 percent of the national payment amount for fiscal year 1988) and a hospital specific portion (25 percent of the hospital specific amount applicable for that hospital for cost reporting periods beginning during fiscal year 1987).

To determine the Federal portion, the labor-related portion of the national standardized amount is multiplied by the appropriate hospital wage index. (See "Source and calculation of the hospital wage index" which accompanies tables 5 and 6.) The wage adjusted labor-related portion is then added to the nonlabor-related portion of the national standardized amount (after adjustment by the applicable cost-of-living factor for hospitals located in Alaska and Hawaii). The resulting total is multiplied by 75 percent (until the 52d day of the hospital's cost reporting period) to determine the Federal portion.

For an example of computing the Federal portion of the PPS payment, assume a sample hospital is located in Washington, D.C. Such a hospital would be in an urban area, in census region 3, and would have a hospital wage index of 1.1051. The Federal portion would be derived by multiplying the labor-related portion of the urban national standardized amount ($2,337.09) by the appropriate hospital wage index (1.1051 for Washington, D.C.) for a wage-adjusted labor-related component of $2,582.72. This component is added to the nonlabor-related portion of the urban national standardized amount ($828.12) for a total of $3,410.84. This amount is multiplied by 75 percent to yield a Federal portion of $2,558.13.

Determination of the hospital-specific portion of the payment

The hospital-specific portion of the payment is based on a hospital's historical cost experience. This is derived for the hospital's 1987 cost reporting year by multiplying the hospital-specific portion used at the end of the prior year by an update factor (this amount is used because either the hospital's cost reporting period that began during fiscal year 1987 has not yet ended, or the hospital has not reached the 52d day of its reporting period that begins during fiscal year 1988). This amount is then multiplied by 25 percent to determine the hospital-specific portion.

For the sample hospital, the hospital-specific portion would look like this:

$3,111.41×1.0115×25 PERCENT=$786.80

Determination of the total payment

The Federal portion of the payment amount would be added to the hospital-specific portion of the payment amount.

For the sample hospital, the sum would be calculated like this:

$2,558.13+$786.80=$3,344.93

To determine the total payment to the hospital for a particular DRG, this total is multiplied by the relative weight for that particular DRG. Each of the 473 DRGs has been assigned its own relative weight. (See table 9 for the relative weights of the 25 highest-volume DRGs.)

For the sample hospital, for DRG 88 (chronic obstructive pulmonary disease), which in fiscal year 1988 has a relative weight of 1.1263, the total payment rate for the hospital in our example would be calculated like this:

$3,344.93×1.1263=$3,767.39

This payment calculation is repeated for each inpatient case at the sample hospital to determine the total payment for the hospital. The DRG weights range from a low of 0.1309 (for DRG 382, false labor) to a high of 11.9225 (for DRG 103, heart transplant).

The payment rates for the sample hospital in fiscal year 1988 would therefore vary from a low of $437.85 ($3,344.93×0.1309) to a high of $39,879.93 ($3,344.93×11.9225).

As described in a previous part of this appendix, additional payments are made for outliers, indirect medical education costs, hospitals that serve a disproportionate share of low-income patients, end-stage renal disease beneficiary discharges, and direct medical education costs. Costs for certain items are excluded from the prospective payment system and are paid on a reasonable cost basis—

such as costs of capital, certain physicians in teaching hospitals, kidney acquisition, anesthesia services of hospital-employed nonphysician anesthetists, and bad debts of Medicare beneficiaries.

TABLE 9.—25 HIGHEST VOLUME DIAGNOSIS RELATED GROUPS, FISCAL YEAR 1987

Fiscal year 1987 rank	DRG No.	Description	Relative weight	Geometric mean length of stay [1]	Outlier threshold [2]
1	127	Heart failure and shock	1.0222	6.2	24
2	140	Angina pectoris	.6689	4.1	14
3	89	Simple pneumonia and pleurisy [3]	1.2862	7.3	25
4	14	Specific cerebrovascular disorders except transient ischemic attacks	1.2429	7.5	25
5	182	Esophagitis, gastroenteritis, and miscellaneous disgestive disorders [3]	.7224	4.9	19
6	430	Psychoses	.9329	8.8	27
7	96	Bronchitis and asthma [3]	.9804	6.0	20
8	138	Cardiac arrhythmia and conduction disorders [3]	.8535	4.8	20
9	296	Nutritional and miscellaneous metabolic disorders [3]	.9259	6.0	24
10	336	Transurethral prostatectomy [3]	1.0774	6.6	19
11	209	Major joint and limb reattachment procedures	2.4145	12.3	28
12	320	Kidney and urinary tract infections [3]	1.0230	6.8	25
13	15	Transient ischemic attacks and precerebral occlusions	.6293	4.2	17
14	174	Gastrointestinal hemorrhage [3]	.9878	5.6	22
15	243	Medical back problems	.6694	5.3	23
16	121	Circulatory disorders with acute myocardial infarction and cardiovascular complications, discharged alive	1.7162	9.4	27
17	88	Chronic obstructive pulmonary disease	1.1263	6.3	24
18	122	Circulatory disorders with acute myocardial infarction, without cardiovascular complications, discharged alive	1.2002	7.3	25
19	468	Unrelated operating room procedures	2.4679	9.9	28
20	148	Major small and large bowel procedures [3]	3.2376	14.5	33
21	210	Hip and femur procedures except major joint [3]	2.1776	13.5	32
22	410	Chemotherapy	.4742	2.4	10
23	79	Respiratory infections and inflammations [3]	2.0777	9.7	28
24	294	Diabetes, age over 35	.7493	6.1	21
25	125	Circulatory disorders except acute myocardial infarction with cardiac catheter without complex diagnosis	.6884	2.5	10

[1] Used to determine payment for outlier and transfer cases.

[2] The day on which outlier payments would begin.

[3] Age over 17 and/or complicating conditions.

Source: Fiscal year 1987 rank from Health Care Financing Administration prospective payment system monitoring tables using preliminary data based on bill records received and processed in HCFA central office through September 25, 1987 NOTE: Values for relative weight, geometric mean length of stay, and outlier threshold are from 52 F.R. 33404, September 1, 1987; these values will be used for fiscal year 1988 discharges.

Source and calculation of the hospital wage index

The hospital wage index is used to adjust a hospital's base payment amount for the wage level of the hospital's area. This is accomplished by multiplying the labor-related component of the Federal portion of the payment amount by a wage index. The wage index is intended to measure the average wage level for hospital workers in each urban area (metropolitan statistical area or MSA) or rural area (non-MSA parts of States) relative to the national average wage level.

Until May 1, 1986, the index was based on compensation and employment data for hospital workers, for calendar year 1981, as reported to the Bureau of Labor Statistics in the U.S. Department of Labor. The wage level for each area was calculated by dividing the total wages and salaries reported by all hospitals in the area, by the total number of hospital employees. The national average wage level was determined by summing the average wages per employee across all areas and dividing the total by the number of areas. Then the wage index for each area was calculated by dividing its average wages per employee by the national average wages per employee.

However, many hospitals use part-time employees and the proportion of part-time employment varies among labor market areas. Therefore, the wage index based on these data tended to understate the true level of hospital hourly wage rates in areas where hospitals place relatively heavy reliance on part-time workers. In addition, the wages per employee figure from each area was counted equally in determining the national average wage level; the wage level for an area with only 400 employees had the same influence on the national average as the wage level for an area with 80,000 employees. As a result, the whole set of area wage indexes was sometimes sensitive to corrections of the data for only a few areas.

The Deficit Reduction Act of 1984 required HHS to conduct a study to develop a new wage index, taking into account differences in the proportions of full-time and part-time employment among hospitals in different areas. If changes were made to the wage index as a result of this study, the Secretary was required to make retroactive adjustments to the PPS payment amounts for hospital cost reporting periods beginning on or after October 1, 1983. The Department surveyed hospitals subject to PPS to obtain total wages and salaries and paid hours of employment data for 1982 and submitted a report to Congress on March 29, 1985, describing two new wage indexes developed from these data.

Both of these indexes resolved the part-time employment problem by calculating the average wage level in each area on the basis of the number of paid hours of employment, rather than on the basis of the number of employees. However, the method of calculating the national average wage level was not changed. Thus, the index was still sensitive to relatively minor corrections in the data.

In final PPS regulations published September 3, 1985 (50 FR 35645), HHS proposed to implement one of these indexes—the gross wage index—effective October 1, 1985. However, Public Law 99-107, as amended by Public Law 99-201, precluded any changes in the PPS payment rates or methodology through March 14, 1986. This was continued through April 30, 1986 by Public Law 99-272. The gross wage index became effective on May 1, 1986.

In final regulations published on September 1, 1987 (52 FR 33039, Sept. 1, 1987), the Secretary changed the method of calculating the national average wage level, and updated the wage index data. The national average wage level is now calculated by dividing national aggregate wages and salaries by the national aggregate number of paid hours of hospital employment. Under this method, the index as a whole is not likely to be sensitive to minor changes in the data for individual labor market areas. The Secretary also decided to implement a new wage index based on data for wages and salaries and paid hours of employment for hospital cost reporting periods beginning during fiscal year 1984 (the first year of the PPS). However, in order to avoid large changes in index values for individual areas, which could result if the index based on 1984 data completely replaced the previous index (based on 1982 data), the Secretary adopted a blended wage index. The blended wage index value for each area is calculated by adding together the 1982 and the 1984 index values for the area and dividing the resulting sum by 2. Wage index values for urban and rural labor market areas located in Puerto Rico are based solely on 1984 data. The new index took effect for discharges occurring on or after October 1, 1987.

Public Law 100-203 (OBRA87) requires the Secretary to update the wage index by October 1, 1990, and at least every 3 years thereafter. Updates are to be based on a periodic survey of the wages and wage related costs of PPS hospitals. To the extent feasible, the survey must be designed to measure earnings and hours of paid employment by occupational category, and to permit exclusion of the wages and wage related costs hospitals incur in providing skilled nursing facility services.

The calculation of the index begins with the area average hospital hourly wage. For each MSA or non-MSA area (i.e., all non-MSA counties in a State) total county compensation and total paid hours data are summed separately over all counties included in the area. Then aggregate hospital compensation for the area is divided by aggregate paid hours of hospital employment in the area to produce the area average hourly wage. The hospital wage index is calculated by dividing the average hourly wage for each area by the national average hourly wage (determined by dividing national aggregate compensation by national aggregate paid hours of employment).

This procedure results in an index number, such as 0.8501 (Asheville, North Carolina) or 1.2140 (Sacramento, California) for each MSA or non-MSA area in the United States. Since the national average wage level is represented by an index value of 1.000, the wage index value for any area has a direct and simple interpretation. The value of 1.2140 for Sacramento means that the average hourly wage rate for hospital workers is 21.4 percent higher in the Sacramento MSA than the national average hourly wage rate.

Thus, in computing the Federal portion of the hospital payment rates applicable for hospitals in the Sacramento MSA, the labor-related component of the national urban adjusted standardized payment amount ($2,337.09) is multiplied by 1.2140 in order to adjust for the higher level (21.4 percent) of hospital hourly wage rates in this area. Similarly, the calculation of the Federal portion of the rates for hospitals in Asheville would involve a reduction in the published labor-related component of the national adjusted standardized payment amount, to reflect the fact that average hourly wage levels in this MSA are 14.99 percent lower than the national average (as indicated by the wage index value of 0.8501).

TABLE 10.—WAGE INDEX FOR URBAN AREAS

Urban area (constituent counties or county equivalents)	Wage index
Abilene, TX	0.8335
Taylor, TX	
Aguadilla, PR	.4624
Aguada, PR, Aguadilla, PR, Isabella, PR, Moca, PR	
Akron, OH	1.0023
Portage, OH, Summit, OH	
Albany, GA	.7748
Dougherty, GA, Lee, GA	
Albany-Schenectady-Troy, NY	.8702
Albany, NY, Greene, NY, Montgomery, NY, Rensselaer, NY, Saratoga, NY, Schenectady, NY	
Albuquerque, NM	1.0188
Bernalillo, MN	
Alexandria, LA	.8182
Rapides, LA	
Allentown-Bethlehem, PA-NJ	.9858
Warren, NJ, Carbon, PA, Lehigh, PA, Northampton, PA	
Altoona, PA	.9474
Blair, PA	
Amarillo, TX	.9326
Potter, TX, Randall, TX	
Anaheim-Santa Ana, CA	1.2031
Orange, CA	
Anchorage, AK	1.4619
Anderson, IN	.9175
Madison, IN	
Anderson, SC	.7839
Ann Arbor, MI	1.1723
Washtenaw, MI	
Anniston, AL	.7847
Calhoun, AL	
Appleton-Oshkosh-Neenah, WI	.9792
Calumet, WI, Outagamie, WI, Winnebago, WI	
Arecibo, PR	.4401
Arecibo, PR, Camuy, PR, Hatillo, PR, Quebradillas, PR	
Asheville, NC	.8501
Buncombe, NC	
Athens, GA	.7710
Clarke, GA, Jackson, GA, Madison, GA, Oconee, GA	
Atlanta, GA	.9196
Barrow, GA, Butts, GA, Cherokee, GA, Clayton, GA, Cobb, GA, Coweta, GA, De Kalb, GA, Douglas, GA, Fayette, GA, Forsyth, GA, Fulton, GA, Gwinnett, GA, Henry, GA, Newton, GA, Paulding, GA, Rockdale, GA, Spalding, GA, Walton, GA	
Atlantic City, NJ	.9898
Atlantic City, Cape May, NJ	
Augusta, GA–SC	.8908
Columbia, GA, McDuffie, GA, Richmond, GA, Aiken, SC	
Aurora-Elgin, IL	1.0123
Kane, IL, Kendall, IL	

TABLE 10.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Austin, TX	1.0409
Hays, TX, Travis, TX, Williamson, TX	
Bakersfield, CA	1.1114
Kern, CA	
Baltimore, MD	1.0178
Anne Arundel, MD, Baltimore, MD, Baltimore City, MD, Carroll, MD, Harford, MD, Howard, MD, Queen Annes, MD	
Bangor, ME	.8907
Penobscot, ME	
Baton Rouge, LA	.8665
Ascension, LA, East Baton Rouge, LA, Livingston, LA, West Baton Rouge, LA	
Battle Creek, MI	.9670
Calhoun, MI	
Beaumont-Port Arthur, TX	.9394
Hardin, TX, Jefferson, TX, Orange, TX	
Beaver County, PA	1.0368
Bellingham, WA	1.0823
Whatcom, WA	
Benton Harbor, MI	.8436
Berrien, MI	
Bergen-Passaic, NJ	1.0299
Billings, MT	.9756
Yellowstone, MT	
Biloxi-Gulfport, MS	.8012
Hancock, MS, Harrison, MS	
Binghamton, NY	.9107
Broome, NY, Tioga, NY	
Birmingham, AL	.9226
Blount, AL, Jefferson, AL, Saint Clair, AL, Shelby, AL, Walker, AL	
Bismarck, ND	.9315
Burleigh, ND, Morton, ND	
Bloomington, IN	.9215
Monroe, IN	
Bloomington-Normal, IL	.9463
McLean, IL	
Boise City, ID	.9821
Ada, ID	
Boston-Lawrence-Salem-Lowell-Brockton, MA	1.0825
Essex, MA, Middlesex, MA, Norfolk, MA, Plymouth, MA, Suffolk, MA	
Boulder-Longmont, CO	1.0717
Boulder, CO	
Bradenton, FL	.8796
Manatee, FL	
Brazoria, TX	.8333
Bremerton, WA	.9407
Kitsap, WA	
Bridgeport-Stamford-Norwalk-Danbury, CT	1.1230
Fairfield, CT	

TABLE 10.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Brownsville-Harlingen, TX	.8538
Cameron, TX	
Bryan-College Station, TX	.9377
Brazos, TX	
Buffalo, NY	.9726
Erie, NY	
Burlington, NC	.7548
Alamance, NC	
Burlington, VT	.9464
Chittenden, VT, Grand Isle, VT	
Caguas, PR	.4001
Caguas, PR, Gurabo, PR, San Lorenz, PR, Aguas Buenas, PR, Cayey, PR, Cidra, PR	
Canton, OH	.9195
Carroll, OH, Stark, OH	
Casper, WY	.9842
Natrona, WY	
Cedar Rapids, IA	.9242
Linn, IA	
Champaign-Urbana-Rantoul, IL	.9141
Charleston, SC	.8467
Berkeley, SC, Charleston, SC, Dorchester, SC	
Charleston, WV	.9757
Kanawha, WV, Putnam, WV	
Charlotte-Gastonia-Rock Hill, NC-SC	.8424
Cabarrus, NC, Gaston, NC, Lincoln, NC, Mecklengburg, NC, Rowan, NC, Union, NC, York, SC	
Charlottesville, VA	.8822
Albermarle, VA, Charlottesville City, VA, Fluvanna, VA, Greene, VA	
Chattanooga, TN-GA	
Catoosa, GA, Dade, GA, Walker, GA, Hamilton, TN, Marion, TN, Sequatchie, TN	
Cheyenne, WY	.8959
Laramie, WY	
Chicago, IL	1.1211
Cook, IL, Du Page, IL, McHenry, IL	
Chico, CA	1.1145
Butte, CA	
Cincinnati, OH-KY-IN	1.0319
Dearborn, IN, Boone, KY, Campbell, KY, Kenton, KY, Clermont, OH, Hamilton, OH, Warren, OH	
Clarksville-Hopkinsville, TN-KY	.7485
Christian, KY, Montgomery, TN	
Cleveland, OH	1.0826
Cuyahoga, OH, Geauga, OH, Lake, OH, Medina, OH	
Colorado Springs, CO	1.0047
El Paso, CO	
Columbia, MO	1.0378
Boone, MO	

TABLE 10.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Columbia, SC	.8450
Lexington, SC, Richland, SC	
Columbus, GA-AL	.7406
Russell, AL, Chattanoochee, GA, Muscogee, GA	
Columbus, OH	.9296
Delaware, OH, Fairfield, OH, Franklin, OH, Licking, OH, Madison, OH, Pickaway, OH, Union, OH	
Corpus Christi, TX	.8801
Nueces, TX, San Patricio, TX	
Cumberland, MD-WV	.8798
Allegeny, MD, Mineral, WV	
Dallas, TX	.9565
Collin, TX, Dallas, TX, Denton, TX, Ellis, TX, Kaufman, TX, Rockwall, TX	
Danville, VA	.7621
Danville City, VA, Pittsylvania, VA	
Davenport-Rock Island-Moline, IA-IL	.9739
Scott, IA, Henry, IL, Rock Island, IL	
Dayton-Springfield, OH	1.0107
Clark, OH, Greene, OH, Miami, OH, Montgomery, OH	
Daytona Beach, FL	.8545
Volusia, FL	
Decatur, IL	.8966
Macon, IL	
Denver, CO	1.1934
Adams, CO, Arapahoe, CO, Denver, CO, Douglas, CO, Jefferson, CO	
Des Moines, IA	.9824
Dallas, IA, Polk, IA, Warren, IA	
Detroit, MI	1.0911
Lapeer, MI, Livingston, MI, Macomb, MI, Monroe, MI, Oakland, MI, Saint Clair, MI, Wayne, MI	
Dothan, AL	.7892
Dale, AL, Houston, AL	
Dubuque, IA	.9712
Duluth, MN–WI	.9477
St. Louis, MN, Douglas, WI	
Eau Claire, WI	.8903
Chippewa, WI, Eau Claire, WI	
El Paso, TX	.8849
Elkhart-Goshen, IN	.9142
Elkhart, IN	
Elmira, NY	.9152
Chemung, NY	
Enid, OK	.9125
Garfield, OK	
Erie, PA	.9488
Eugene-Springfield, OR	1.0353
Lane, OR	
Evansville, IN-KY	.9963
Posey, IN, Vanderburgh, IN, Warrick, IN, Henderson, KY	

TABLE 10.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Fargo-Moorhead, ND-MN Clay, MN, Cass, ND	1.0031
Fayetteville, NC Cumberland, NC	.7983
Fayetteville-Springdale, AR Washington, AR	.7494
Flint, MI Genesee, MI, Shiawassee, MI	1.1458
Florence, AL Colbert, AL, Lauderdale, AL	.7255
Florence, SC	.7472
Fort Collins-Loveland, CO Larimor, CO	1.0252
Fort Lauderdale-Hollywood-Pompano Beach, FL Broward, FL	1.0424
Fort Myers-Cape Coral, FL Lee, FL	.8989
Fort Pierce, FL Martin, FL, St. Lucie, FL	1.0052
Fort Smith, AR–OK Crawford, AR, Sebastian, AR, Sequoyah, OK	.8726
Fort Walton Beach, FL Okaloosa, FL	.8210
Fort Wayne, IN Allen, IN, De Kalb, IN, Whitley, IN	.9008
Fort Worth-Arlington, TX Johnson, TX, Parker, TX, Tarrant, TX	.9475
Fresno, CA	1.0978
Gadsden, AL Etowah, AL	.8394
Gainesville, FL Alachua, FL, Bradford, FL	.8902
Galveston-Texas City, TX Galveston, TX	1.0782
Gary-Hammond, IN Lake, IN, Porter, IN	1.0415
Glens Falls, NY Warren, NY, Washington, NY	.8889
Grand Forks, ND	.9462
Grand Rapids, MI Kent, MI, Ottawa, MI	1.0058
Great Falls, MT Cascade, MT	.9966
Greeley, CO Weld, CO	1.0174
Green Bay, WI Brown, WI	.9692
Greensboro-Winston-Salem-High Point, NC Davidson, NC, Davie, NC, Forsyth, NC, Guilford, NC, Randolph, NC, Stokes, NC, Yadkin, NC	.8710

TABLE 10.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Greenville-Spartanburg, SC Greenville, SC, Pickens, SC, Spartanburg, SC	.8961
Hagerstown, MD Washington, MD	.8869
Hamilton-Middletown, OH Butler, OH	.9649
Harrisburg-Lebanon-Carlisle, PA Cumberland, PA, Dauphin, PA, Lebanon, PA, Perry, PA	.9907
Hartford-Middletown-New Britain-Bristol, CT Hartford, CT, Litchfield, CT, Middlesex, CT, Tolland, CT	1.0898
Hickory, NC Alexander, NC, Burke, NC, Catawba, NC	.8335
Honolulu, HI	1.1343
Houma-Thibodaux, LA Lafourche, LA, Terrebonne, LA	.8083
Houston, TX Fort Bend, TX, Harris, TX, Liberty, TX, Montgomery, TX, Waller, TX	.9868
Huntington-Ashland, WV-KY-OH Boyd, KY, Carter, KY, Greenup, KY, Lawrence, OH, Cabell, WV, Wayne, WV	.9066
Huntsville, AL Madison, AL	.8208
Indianapolis, IN Boone, IN, Hamilton, IN, Hancock, IN, Hendricks, IN, Johnson, IN, Marion, IN, Morgan, IN, Shelby, IN	.9941
Iowa City, IA Johnson, IA	1.1630
Jackson, MI	.9445
Jackson, MS Hinds, MS, Madison, MS, Rankin, MS,	.8439
Jackson, TN Madison, TN	.7506
Jacksonville, FL Clay, FL, Duval, FL, Nassau, FL, St. Johns, FL	.8923
Jacksonville, NC Onslow, NC	.7358
Janesville-Beloit, WI Rock, WI	.8935
Jersey City, NJ Hudson, NJ	1.0599
Johnson City-Kingsport-Bristol, TN-VA Carter, TN, Hawkins, TN, Sullivan, TN, Unicoi, TN, Washington, TN, Bristol City, VA, Scott, VA, Washington, VA	.8446
Johnstown, PA Cambria, PA, Somerset, PA	.9060
Joliet, IL Grundy, IL, Will, IL	1.0507

TABLE 10.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Joplin, MO	.8649
Jasper, MO, Newton, MO	
Kalamazoo, MI	1.1352
Kankakee, IL	.8989
Kansas City, KS-MO	1.0064
Johnson, KS, Leavenworth, KS, Miami, KS, Wyandotte, KS, Cass, MO, Clay, MO, Jackson, MO, Lafayette, MO, Platte, MO, Ray, MO	
Kenosha, WI	1.0384
Killeen-Temple, TX	.9789
Bell, TX, Coryell, TX	
Knoxville, TN	.8335
Anderson, TN, Blount, TN, Grainger, TN, Jefferson, TN, Knox, TN, Sevier, TN, Union, TN	
Kokomo, IN	.9352
Howard, IN, Tipton, IN	
LaCrosse, WI	.9629
Lafayette, LA	.9261
Lafayette, LA, St. Martin, LA	
Lafayette, IN	.8736
Tippecanoe, IN	
Lake Charles, LA	.9172
Calcasieu, LA	
Lake County, IL	1.0904
Lake, IL	
Lakeland-Winter Haven, FL	.8261
Polk, FL	
Lancaster, PA	.9866
Lancaster, PA	
Lansing-East Lansing, MI	1.0251
Clinton, MI, Eaton, MI, Ingham, MI	
Laredo, TX	.7521
Webb, TX	
Las Cruces, NM	.8362
Dona Ana, NM	
Las Vegas, NV	1.0873
Clark, NV	
Lawrence, KS	.9748
Douglas, KS	
Lawton, OK	.8579
Comanche, OK	
Lewiston-Auburn, ME	.9034
Androscoggin, ME	
Lexington-Fayette, KY	.9227
Bourbon, KY, Clark, KY, Fayette, KY, Jessamine, KY, Scott, KY, Woodford, KY	
Lima, OH	.9233
Allen, OH, Auglaize, OH	
Lincoln, NE	.9287
Lancaster, NE	

TABLE 10.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Little Rock-North Little Rock, AR Faulkner, AR, Lonoke, AR, Pulaski, AR, Saline, AR	.9376
Longview-Marshall, TX Gregg, TX, Harrison, TX	.8037
Lorain-Elyria, OH Lorain, OH	.9519
Los Angeles-Long Beach, CA Los Angeles, CA	1.2463
Louisville, KY-IN Clark, IN, Floyd, IN, Harrison, IN, Bullitt, KY, Jefferson, KY, Oldham, KY, Shelby, KY	.9520
Lubbock, TX	.9568
Lynchburg, VA Amherst, VA, Campbell, VA, Lynchburg City, VA	.8586
Macon-Warner Robins, GA Bibb, GA, Houston, GA, Jones, GA, Peach, GA	.8287
Madison, WI Dane, WI	1.0167
Manchester-Nashua, NH Hillsborough, NH, Merrimack, NH	.9222
Mansfield, OH Richland, OH	.9116
Mayaguez, PR Anasco, PR, Cabo Rojo, PR, Hormigueros, PR, Mayaguez, PR, San German, PR	.4842
McAllen-Edinburg-Mission, TX Hidalgo, TX	.7655
Medford, OR Jackson, OR	.9701
Melbourne-Titusville, FL Brevard, FL	.8862
Memphis, TN-AR-MS Crittenden, AR, De Soto, MS, Shelby, TN, Tipton, TN	.9644
Merced, CA	1.0727
Miami-Hialeah, FL Dade, FL	1.0151
Middlesex-Somerset-Hunterdon, NJ Hunterdon, NJ, Middlesex, NJ, Somerset, NJ	.9837
Midland, TX	1.0576
Milwaukee, WI Milwaukee, WI, Ozaukee, WI, Washington, WI, Waukesha, WI	1.0435
Minneapolis-St. Paul, MN-WI Anoka, MN, Carver, MN, Chisago, MN, Dakota, MN, Hennepin, MN, Isanti, MN, Ramsey, MN, Scott, MN, Washington, MN, Wright, MN, St. Croix, WI	1.1224
Mobile, AL Baldwin, AL, Mobile, AL	.8319
Modesto, CA Stanislaus, CA	1.1049

TABLE 10.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Monmouth-Ocean, NJ	.9365
Monmouth, NJ, Ocean, NJ	
Monroe, LA	.8471
Ouachita, LA	
Montgomery, AL	.8173
Autauga, AL, Elmore, AL, Montgomery, AL	
Muncie, IN	.9565
Delaware, IN	
Muskegon, MI	.9620
Naples, FL	.9919
Collier, FL	
Nashville, TN	.8878
Cheatham, TN, Davidson, TN, Dickson, TN, Robertson, TN, Rutherford, TN, Sumner, TN, Williamson, TN, Wilson, TN	
Nassau-Suffolk, NY	1.2359
Nassau, NY, Suffolk, NY	
New Bedford-Fall River-Attleboro, MA	.9352
Bristol, MA	
New Haven-Waterbury-Meriden, CT	1.0693
New Haven, CT	
New London-Norwich, CT	1.0562
New London, CT	
New Orleans, LA	.9080
Jefferson, LA, Orleans, LA, St. Bernard, LA, St. Charles, LA, St. John The Baptist, LA, St. Tammany, LA	
New York, NY	1.3092
Bronx, NY, Kings, NY, New York City, NY, Putnam, NY, Queens, NY, Richmond, NY, Rockland, NY, Westchester, NY	
Newark, NJ	1.0808
Essex, NJ, Morris, NJ, Sussex, NJ, Union, NJ	
Niagara Falls, NY	.8492
Norfolk-Virginia Beach-Newport News, VA	.9196
Chesapeake City, VA, Gloucester, VA, Hampton City, VA, James City Co., VA, Newport News City, VA, Norfolk City, VA, Poquoson, VA, Portsmouth City, VA, Suffolk City, VA, Virginia Beach City, VA, Williamsburg City, VA, York, VA	
Oakland, CA	1.4023
Alameda, CA, Contra Costa, CA	
Ocala, FL	.8183
Marion, FL	
Odessa, TX	.8919
Ector, TX	
Oklahoma City, OK	1.0065
Canadian, OK, Cleveland, OK, Logan, OK, McClain, OK, Oklahoma, OK, Pottawatomie, OK	
Olympia, WA	1.0349
Thurston, WA	
Omaha, NE-IA	.9822
Pottawattamie, IA, Douglas, NE, Sarpy, NE, Washington, NE	

TABLE 10.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Orange County, NY Orange, NY	.8828
Orlando, FL Orange, FL, Osceola, FL, Seminole, FL	.9356
Owensboro, KY Daviess, KY	.8360
Oxnard-Ventura, CA Ventura, CA	1.2976
Panama City, FL Bay, FL	.7882
Parkersburg-Marietta, WV-OH Washington, OH, Wood, WV	.8828
Pascugoula, MS Jackson, MS	.8929
Pensacola, FL Escambia, FL, Santa Rosa, FL	.8241
Peoria, IL Peoria, IL, Tazewell, IL, Woodford, IL	.9879
Philadelphia, PA-NJ Burlington, NJ, Camden, NJ, Gloucester, NJ, Bucks, PA, Chester, PA, Delaware, PA, Montgomery, PA, Philadelphia, PA	1.0935
Phoenix, AZ Maricopa, AZ	1.0079
Pine Bluff, AR Jefferson, AR	.7767
Pittsburgh, PA Allegheny, PA, Fayette, PA, Washington, PA, Westmoreland, PA	1.0240
Pittsfield, MA Berkshire, MA	.9946
Ponce, PR Juana Diaz, PR, Ponce, PR	.5513
Portland, ME Cumberland, ME, Sagadahoc, ME, York, ME	.9461
Portland, OR Clackamas, OR, Multnomah, OR, Washington, OR, Yamhill, OR	1.1292
Portsmouth-Dover-Rochester, NH Rockingham, NH, Strafford, NH	.9114
Poughkeepsie, NY Dutchess, NY	.9597
Providence-Pawtucket-Woonsocket, RI Bristol, RI, Kent, RI, Newport, RI, Providence, RI, Washington, RI	.9811
Provo-Orem, UT Utah, UT	.9278
Pueblo, CO Pueblo, CO	.9920
Racine, WI	.9299
Raleigh-Durham, NC Durham, NC, Franklin, NC, Orange, NC, Wake, NC	.9274

TABLE 10.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Rapid City, SD Pennington, SD	.8702
Reading, PA Berks, PA	.9381
Redding, CA Shasta, CA	1.0779
Reno, NV Washoe, NV	1.1202
Richland-Kennewick, WA Benton, WA, Franklin, WA	.9688
Richmond-Petersburg, VA Charles City Co., VA, Chesterfield, VA, Colonial Heights City, VA, Dinwiddie, VA, Goochland, VA, Hanover, VA, Henrico, VA, Hopewell City, VA, New Kent, VA, Petersburg City, VA, Powhatan, VA, Prince George, VA, Richmond City, VA	.8897
Riverside-San Bernardino, CA Riverside, CA, San Bernardino, CA	1.1536
Roanoke, VA Botetourt, VA, Roanoke, VA, Roanoke City, VA, Salem City, VA	.8346
Rochester, MN Olmsted, MN	1.0027
Rochester, NY Livingston, NY, Monroe, NY, Ontario, NY, Orleans, NY, Wayne, NY	.9558
Rockford, IL Boone, IL, Winnebago, IL	1.0245
Sacramento, CA Eldorado, CA, Placer, CA, Sacramento, CA, Yolo, CA	1.2140
Saginaw-Bay City-Midland, MI Bay, MI, Midland, MI, Saginaw, MI	1.0597
St. Cloud, MN Benton, MN, Sherburne, MN, Stearns, MN	.9662
St. Joseph, MO Buchanan, MO	.8811
St. Louis, MO-IL Clinton, IL, Jersey, IL, Madison, IL, Monroe, IL, St. Clair, IL, Franklin, MO, Jefferson, MO, St. Charles, MO, St. Louis, MO, St. Louis City, MO	1.0165
Salem, OR Marion, OR, Polk, OR	1.0416
Salinas-Seaside-Monterey, CA Monterey, CA	1.2211
Salt Lake City-Ogden, UT Davis, UT, Salt Lake, UT, Weber, UT	.9508
San Angelo, TX Tom Green, TX	.8302
San Antonio, TX Bexar, TX, Comal, TX, Guadalupe, TX	.8377
San Diego, CA	1.2350
San Francisco, CA Marin, CA, San Francisco, CA, San Mateo, CA	1.4946

TABLE 10.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
San Jose, CA	1.4323
Santa Clara, CA	
San Juan, PR	.5387
Barcelona, PR, Bayoman, PR, Canovanas, PR, Carolina, PR, Catano, PR, Corozal, PR, Dorado, PR, Fajardo, PR, Florida, PR, Guaynabo, PR, Humacao, PR, Juncos, PR, Los Piedras, PR, Loiza, PR, Luguillo, PR, Manati, PR, Naranjito, PR, Rio Grande, PR, San Juan, PR, Toa Alta, PR, Toa Baja, PR, Trojillo Alto, PR, Vega Alta, PR, Vega Baja, PR	
Santa Barbara-Santa Maria-Lompoc, CA	1.1428
Santa Barbara, CA	
Santa Cruz, CA	1.2017
Santa Fe, NM	.9362
Los Alamos, NM, Santa Fe, NM	
Santa Rosa-Petaluma, CA	1.2943
Sonoma, CA	
Sarasota, FL	.9166
Savannah, GA	.8405
Chatham, GA, Effingham, GA	
Scranton-Wilkes Barre, PA	.9318
Columbia, PA	
Lackawanna, PA, Luzerne, PA, Monroe, PA, Wyoming, PA	
Seattle, WA	1.0907
King, WA, Snohomish, WA	
Sharon, PA	.9198
Mercer, PA	
Sheboygan, WI	.9318
Sherman-Denison, TX	.8285
Grayson, TX	
Shreveport, LA	.8994
Bossier, LA, Caddo, LA	
Sioux City, IA-NE	.9248
Woodbury, IA, Dakota, NE	
Sioux Falls, SD	.9552
Minnehaha, SD	
South Bend-Mishawaka, IN	.9605
St. Joseph, IN	
Spokane, WA	1.0823
Springfield, IL	1.0040
Menard, IL, Sangamon, IL	
Springfield, MO	.9074
Christian, MO, Greene, MO	
Springfield, MA	.9758
Hampden, MA, Hampshire, MA	
State College, PA	1.0303
Centre, PA	
Steubenville-Weirton, OH-WV	.9106
Jefferson, OH, Brooke, WV, Hancock, WV	
Stockton, CA	1.1743
San Joaquin, CA	

TABLE 10.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Syracuse, NY Madison, NY, Onondaga, NY, Oswego, NY	.9730
Tacoma, WA Pierce, WA	1.0325
Tallahassee, FL Gadsden, FL, Leon, FL	.8531
Tampa-St. Petersburg-Clearwater, FL Hernando, FL, Hillsborough, FL, Pasco, FL, Pinellas, FL	.9125
Terre Haute, IN Clay, IN, Vigo, IN	.8090
Texarkana-TX-Texarkana, AR Miller, AR, Bowie, TX	.8071
Toledo, OH Fulton, OH, Lucas, OH, Wood, OH	1.1101
Topeka, KS Shawnee, KS	.9955
Trenton, NJ	1.0014
Tucson, AZ Pima, AZ	.9639
Tulsa, OK Creeks, OK, Osage, OK, Rogers, OK, Tulsa, OK, Wagoner, OK	.9346
Tuscaloosa, AL	.9515
Tyler, TX Smith, TX	.9326
Utica-Rome, NY Herkimer, NY, Oneida, NY	.8211
Vallejo-Fairfield-Napa, CA Napa, CA, Solano, CA	1.2767
Vancouver, WA Clark, WA	1.0772
Victoria, TX	.7993
Vineland-Millville-Bridgeton, NJ Cumberland, NJ	.9580
Visalia-Tulare-Porterville, CA Tulare, CA	1.1418
Waco, TX McLennan, TX	.8585
Washington, D.C.-MD-VA District of Columbia, DC, Calvert, MD, Charles, MD, Frederick, MD, Montgomery, MD, Prince Georges, MD, Alexandria City, VA, Arlington, VA, Fairfax, VA, Fairfax City, VA, Falls Church City, VA, Loudoun, VA, Manassas City, VA, Manassas Park City, VA, Prince William, VA, Stafford, VA	1.1051
Waterloo-Cedar Falls, IA Black Hawk, IA, Bremer, IA	.9432
Wausau, WI Marathan, WI	.9457
West Palm Beach-Boca Raton-Delray Beach, FL Palm Beach, FL	.9431

TABLE 10.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Wheeling, WV-OH Belmont, OH, Marshall, WV, Ohio, WV	.8761
Wichita, KS Butler, KS, Harvey, KS, Sedgwick, KS	1.0469
Wichita Falls, TX Wichita, TX	.8221
Williamsport, PA Lycoming, PA	.8804
Wilmington, DE-NJ-MD New Castle, DE, Cecil, MD, Salem, NJ	1.0125
Wilmington, NC New Hanover, NC	.8602
Worcester-Fitchburg-Leominster, MA Worcester, MA	.9460
Yakima, WA	.9850
York, PA Adams, PA, York, PA	.9340
Youngstown-Warren, OH Mahoning, OH, Trumball, OH	.9942
Yuba City, CA Sutter, CA, Yuba, CA	.9970

TABLE 11.—WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage index	Nonurban area	Wage index
Alabama	0.7005	Michigan	.9036
Alaska	1.3922	Minnesota	.8605
Arizona	.8869	Mississippi	.7215
Arkansas	.7124	Missouri	.7640
California	1.0428	Montana	.8558
Colorado	.8666	Nebraska	.7751
Connecticut	1.0013	Nevada	.9817
Delaware	.8236	New Hampshire	.8784
Florida	.8223	New Jersey[1]	
Georgia	.7385	New Mexico	.8359
Hawaii	.9318	New York	.8124
Idaho	.8489	North Carolina	.7650
Illinois	.8188	North Dakota	.8463
Indiana	.8104	Ohio	.8609
Iowa	.8070	Oklahoma	.7938
Kansas	.7927	Oregon	1.0029
Kentucky	.7754	Pennsylvania	.8807
Louisiana	.7856	Puerto Rico	.5536
Maine	.8191	Rhode Island[1]	
Maryland	.8112	South Carolina	.7232
Massachusetts	1.0033	South Dakota	.7668

TABLE 11.—WAGE INDEX FOR RURAL AREAS—Continued

Nonurban area	Wage index	Nonurban area	Wage index
Tennessee	.7162	Virgin Island[1]	
Texas	.7591	Washington	.9805
Utah	.8782	West Virginia	.8414
Vermont	.8387	Wisconsin	.8458
Virginia	.7833	Wyoming	.9100

[1] All counties within the State are classified urban.

Special treatment of certain facilities

Certain exceptions and adjustments to the prospective payment rates are provided as follows:

Sole community hospitals

Sole community hospitals (SCHs), are hospitals that (by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals nearby) provide the only source of inpatient services reasonably available in a geographic area. Public Law 98-21 requires the Secretary to determine the DRG payment rates for these hospitals on the same basis used to pay all hospitals during the first year of the transition period: the SCH's base payment amount per discharge is equal to 75 percent of the hospital specific amount plus 25 percent of the Federal regional amount. The legislation also requires the Secretary to adjust the PPS payment rates for an SCH, for a cost reporting period beginning on or after October 1, 1983, but before October 1, 1986, if the hospital experiences a decrease of more than 5 percent in its total volume of discharges, due to circumstances beyond its control. The amount of the payment adjustment must fully compensate the hospital for the fixed costs it incurs in providing inpatient services, including reasonable costs of maintaining necessary core staff and services.

Public Law 99-509 extended the period of eligibility for a payment adjustment for a decrease in volume of discharges, until October 1, 1988; OBRA87 extended the period to October 1, 1990. OBRA87 also provides that, effective October 1, 1987, a hospital may receive this payment adjustment if it meets the sole community hospital criteria, but is not being paid as a sole community hospital. The total amount of additional payments to hospitals which qualify under the last provision, is limited to $5 million in fiscal year 1988 and $10 million in fiscal year 1989.

For cost reporting periods beginning on or after October 1, 1983, and before October 1, 1989, Public Law 99-272 provided that an SCH experiencing an increase in operating costs due to the addition of new inpatient facilities or services will receive an adjustment to its hospital specific amount for such costs. As of June 1986, 362 hospitals had been classified as sole community providers.

Cancer hospitals

The Secretary is authorized to provide for exceptions and adjustments to the prospective payment amounts appropriate for hospitals involved extensively in treatment for and research on cancer. The regulations define a cancer hospital as one which: (1) was recognized by the National Cancer Institute as a comprehensive cancer center or a clinical cancer research center as of April 20, 1983, (2) demonstrates that the entire facility is organized primarily for treatment of and research on cancer, and (3) has a patient population such that at least 50 percent of the hospital's total discharges have a principal diagnosis that reflects a finding of neoplastic disease. Cancer hospitals meeting these criteria may elect to be paid on a reasonable cost basis, subject to TEFRA limits. As of June 1986, six hospitals had been designated as cancer hospitals.

Referral centers

The Secretary is authorized to provide exceptions and adjustments as appropriate for regional and national referral centers. These centers are defined as:

(1) rural hospitals having 500 or more beds;

(2) hospitals having at least 50 percent of their Medicare patients referred from other hospitals or from physicians not on the hospital's staff, at least 60 percent of their Medicare patients residing more than 25 miles from the hospital, and at least 60 percent of the services furnished to Medicare beneficiaries are furnished to those who live 25 miles or more from the hospital; or

(3) rural hospitals meeting the following criteria for hospital cost reporting periods beginning on or after October 1, 1985.

(a) a case mix index equal to or greater than the median case mix for all urban hospitals (the national standard), or the median case mix for urban hospitals located in the same census region, excluding hospitals with approved teaching programs. (The case mix index is a measure of the relative costliness of the hospital's mixture of cases among the DRGs compared to the national average mixture of medicare cases);

(b) a minimum of 5,000 discharges, the national discharge criterion (3,000 in the case of osteopathic hospitals), or the median number of discharges in urban hospitals for the region in which the hospital is located; and

(c) at least one of the following three criteria: more than 50 percent of the hospital's medical staff are specialists, at least 60 percent of discharges are for inpatients who reside more than 25 miles from the hospital, or at least 40 percent of inpatients treated at the hospital have been referred either from physicians not on the hospital's staff or from other hospitals.

Referral centers are paid prospective payments based on the applicable urban payment amount rather than the rural payment amount, as adjusted by the hospital's area wage index.

Under the regulations, once a hospital has achieved referral center status, it is paid at the applicable urban rate for a 3-year period. Public Law 99-509 permitted hospitals designated as regional referral centers, as of the date of enactment, to continue their designation for 3 additional years. As of June 1986, 167 hospitals were qualified as referral centers.

Public Law 100-203 reduced the minimum number of beds criterion for hospitals located in a rural area, from 500 to 275, effective for discharges occurring on or after April 1, 1988. The legislation also requires the Secretary to study and report to Congress, by May 1, 1989, on (1) the referral center criteria, including, for hospitals currently designated as referral centers, the relationship of their PPS payments to their costs of inpatient care, and the appropriateness of payment on the basis of some rate other than the urban rate, and; (2) recommendations regarding criteria to be used in designating referral centers for cost reporting periods beginning on or after October 1, 1989.

Hospitals excluded from the prospective payment system

The following hospitals are by law excluded from the prospective payment system and are paid on the basis of reasonable costs, subject to the TEFRA rate of increase limits: psychiatric hospitals, rehabilitation hospitals, psychiatric or rehabilitation units which are distinct parts of a hospital, alcohol and drug abuse hospitals and such distinct units of hospitals (for cost reporting periods beginning before October 1, 1987), children's hospitals (with patients averaging under 18 years of age), long-term hospitals (with an average inpatient length of stay greater than 25 days), and hospitals outside the 50 States and the District of Columbia. Public Law 99-509 provided that hospitals located in Puerto Rico will be included in PPS, specially adjusted for Puerto Rico, effective with discharges occurring on or after October 1, 1987.

Hospitals reimbursed under approved State cost control systems are also excluded from the prospective rates. In addition, there are special cases where the prospective payment system is not applied, such as for emergency services provided to Medicare beneficiaries in hospitals not participating in Medicare, Veterans' Administration hospital services provided to Medicare beneficiaries, and hospital services provided to Medicare beneficiaries who belong to health maintenance organizations or competitive medical plans (such organizations may choose to have the Secretary pay hospitals directly for such services or may negotiate their own rates with hospitals).

Administrative and judicial review

Administrative and judicial appeals are allowed under procedures and authorities already established under the Medicare program. However, the law precludes administrative and judicial review of: (1) the "budget neutrality" adjustment (see above), and (2) the DRG payment amounts, including the establishment of DRG's, the methodology for classifying discharges within DRG's, and the DRG weighting factors.

Review activities

Public Law 97-248, the Tax Equity and Fiscal Responsibility Act of 1982 (known as TEFRA) replaced the existing Professional

Standards Review Organization (PSRO) program with the utilization and quality control peer review program. The Secretary of the Department of Health and Human Services was required to enter into performance-based contracts with physician-sponsored or physician-access organizations known as Peer Review Organizations (PRO's) by November 15, 1984. As a condition of receiving payments under the prospective payment system, hospitals are required to enter an agreement with a PRO under which the PRO will review the validity of diagnostic and procedural information provided by the hospitals; the completeness, adequacy and quality of care provided; and the appropriateness of admissions patterns, discharges, lengths of stay, transfers, and services furnished in outlier cases.

Nonphysician services furnished to hospital inpatients

Prior to Public Law 98-21, payments for nonphysician services (in such areas as radiology, laboratory, physical therapy, prosthetics) provided to Medicare beneficiaries who were hospital inpatients were made either (1) to the hospital under part A of Medicare on a reasonable cost basis or (2) to an outside supplier of the service under part B of Medicare on the basis of reasonable charges. The practice of billing under part B for services provided to hospital inpatients is known as the "unbundling" of part A services.

Public Law 98-21 provided that, effective October 1, 1983, for all hospitals participating in the Medicare program (including those under prospective payment, excluded hospitals, and those paid under State cost control systems), all nonphysician services provided to hospital inpatients will be paid only as hospital services under the part A program. The Secretary has authority to waive this requirement during the transition period to allow billing under part B for hospitals that had such extensive billings under part B prior to October 1, 1982, that compliance with the new requirement would threaten the stability of patient care (commonly referred to as 602k hospitals). As of December 1985, there were four 602k hospitals.

January 3, 1984 regulations provided for an exception to the "unbundling" requirement for the inpatient hospital services of nonphysician anesthetists, such as certified registered nurse anesthetists (CRNAs). For hospital cost reporting periods beginning before October 1, 1986, if a physician (usually an anesthesiologist) employed nonphysician anesthetists on the last day of the hospital's most recent cost reporting period ending before September 1, 1983, then the physician could continue to bill the Medicare program for the nonphysician anesthetists' services under part B of Medicare. If the physician chose to continue such part B billing during the transition period, the hospital may not add the costs of such services to its base period costs for purposes of determining the hospital-specific portion of its DRG payment rates.

Public Law 98-369 (DEFRA) provided that, effective with cost reporting periods beginning October 1, 1984, and before October 1, 1987, the costs of anesthesia services provided by qualified nonphysician anesthetists (CRNAs and anesthesiology assistants) employed by hospitals or obtained under arrangements are removed from prospective payment, to be reimbursed on the basis of reasonable cost.

Public Law 99-509 extended the existing payment arrangements for services of CRNAs employed by hospitals for 1 additional year. In addition, it provided for direct reimbursement of CRNAs for services provided on or after January 1, 1989 (for additional detail, see "Anesthesia services of hospital-employed nonphysician anesthetists," above).

State cost control systems

Section 1886(c) of the Social Security Act (as added by TEFRA) gave the HHS Secretary discretion to reimburse hospitals in a State according to the State's hospital reimbursement control system rather than according to Medicare's reimbursement methods if the State requests this change and if HHS determines that the State system meets certain requirements. Currently two States have waivers to operate their own systems: Maryland and New Jersey.

Public Laws 98-21 and 98-369 added several more requirements for State systems. According to final regulations published by HHS on April 24, 1986 (51 F.R. 15481), implementing these legislative changes, HHS has the discretion to allow Medicare hospital reimbursement to be made in accordance with a State reimbursement control system if the chief executive officer of the State requests approval of the State system, and provided that the State system:

(a) Applies to substantially all non-federal acute care hospitals in the State.

(b) Applies to at least 75 percent of all inpatient revenues or expenses for the State.

(c) Provides assurances that payers, hospital employees and patients in the State will be treated equitably under its system.

(d) Provides assurances that its system will not result in greater Medicare expenditures over 36-month periods.

(e) Does not preclude health maintenance organizations (HMOs) or competitive medical plans (CMPs) from negotiating directly with hospitals concerning payment for inpatient services.

(f) Limits hospital charges to Medicare beneficiaries to deductibles, coinsurance, and services for which the beneficiary would not be entitled to have payment made under Medicare Part A; and prohibits payment under Part B of Medicare for nonphysician services provided to hospital inpatients unless this prohibition is waived.

HHS must approve any State system which meets the above six requirements and also the following requirements. The State system must:

(g) Be operated directly by the State or an entity designated by State law.

(h) Use a payment methodology to be applied prospectively.

(i) Provide for hospital reports, as required by the Secretary.

(j) Provide satisfactory assurances that it will not result in admission practices that will reduce treatment to uninsured, low income, high cost, or emergency patients.

(k) Not materially reduce payments without 60 days notice to the Secretary and to affected hospitals.

(l) Provide satisfactory assurance that, in developing its system, the State has consulted with local officials concerning the impact on public hospitals.

Special provisions apply to States that have existing demonstration projects approved by HCFA under section 402 of the Social Security Amendments of 1967 or section 222(a) of the Social Security Amendment of 1972 for the operation of State reimbursement control systems. HHS approval of a State's application to continue the operation of a system upon expiration of the demonstration project is mandatory if, and for so long as, the system meets the minimum requirements described in items (a) through (f) above.

PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Public Law 98-21 required the Director of the Congressional Office of Technology Assessment (OTA) to appoint by April 1, 1984, a commission of 15 independent experts, known as the Prospective Payment Assessment Commission (ProPAC). Public Law 99-272 added two members to ProPAC, bringing the total to 17 members.

ProPAC is required to review the percentage increase used to update the DRG payment rates for fiscal years 1984 and 1985. It is required to make recommendations, in a report due by April 1, to the Secretary on the appropriate percentage change beginning with fiscal year 1986. This report is due by March 1, beginning with recommendations for fiscal year 1989. In addition, the Commission must: (1) consult with and make recommendations to the Secretary on the need for adjustments to the DRG classifications, the methodology for classifying specific hospital discharges within the DRGs, and weighting factors for the DRGs; [2] and (2) report to Congress its evaluation of any adjustments which the Secretary makes.[3]

Each year, ProPAC also submits a report to Congress which provides background information on trends in health care delivery and financing, including the impact of the prospective payment system on providers and beneficiaries. Prior to 1988, this report to Congress was submitted in February each year. Because the Commission's report and recommendations to the Secretary is due earlier, however, the report to Congress has been rescheduled for June 1, each year.

The following tables, from various ProPAC reports provide background information regarding recent trends in hospital utilization.

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[2] See Prospective Payment Assessment Commission. Report and Recommendation to the Secretary, U.S. Department of Health and Human Services, March 1, 1988.

[3] See Prospective Payment Assessment Commission, 1988 Adjustments to the Medicare Prospective Payment System. Report to Congress, November 1987.

TABLE 12.—PERCENT CHANGE IN HOSPITAL ADMISSIONS FOR PERSONS UNDER AGE 65 AND FOR PERSONS OVER AGE 65

Year	All admissions	Admissions Under age 65	Admissions over age 65
1980	2.9	1.5	6.7
1981	.9	.0	3.0
1982	.0	−1.6	4.1
1983	−0.5	−2.8	4.7
1984	−3.7	−4.2	−2.6
1985	−4.9	−4.7	−5.2
1986	−2.1	−2.5	−1.2
1987 [1]	−.7	−1.0	−.2
Average change, 1970–79	2.6	1.8	4.7
Average change, 1980–83	0.8	−0.7	4.6
Average change, 1984–87 [1]	−2.9	−3.1	−2.3

[1] Estimate based on January through September 1986 compared with January through September 1987.

Source: American Hospital Association National Panel Survey.

TABLE 13.—CHANGE IN OCCUPANCY RATES AND NUMBERS OF BEDS, 1976–86

Year	Occupancy rates (percent)	Percent change	Number of beds	Percent change
1976	74.6	−0.1	933,119	3.0
1977	74.4	−0.3	945,208	1.3
1978	73.8	−0.8	954,001	0.9
1979	74.5	1.0	959,269	0.6
1980	75.9	1.9	970,456	1.2
1981	75.8	−0.1	986,917	1.7
1982	74.6	−1.6	997,720	1.1
Average increase 1976–82	74.8	−0.01	963,813	1.4
1983	72.2	−3.2	1,003,658	0.6
1984	66.6	−7.8	992,616	−1.1
1985	63.6	−4.5	974,559	−1.8
1986 [1]		−0.9		−1.0
Average increase 1983–86	66.6	−4.1	983,797	−0.8

[1] Estimate based on January through August 1985 compared with January through August 1986.

Source: American Hospital Association National Panel Survey, as reported in Prospective Payment Assessment Commission. Medicare Prospective Payment and the American Health Care System, Report to the Congress, February 1987.

TABLE 14.—CHANGE IN LENGTH OF STAY, ALL ADULTS AND ADULTS OVER AGE 65, 1980–1987

[In percent]

Year	All adults length of stay	Percent change	Adults over 65 length of stay	Percent change
1976	7.4	0.0	11.0	−1.8
1977	7.2	−2.7	10.7	−2.7
1978	7.2	.0	10.6	− .9
1979	7.1	−1.4	10.4	−1.9
1980	7.2	.5	10.4	−.1
1981	7.2	.4	10.4	−.1
1982	7.2	−.6	10.1	−2.3
1983	7.0	−2.0	9.7	−4.5
1984	6.7	−5.1	8.9	−7.6
1985	6.5	−2.4	8.8	−2.0
1986	6.6	1.5	8.8	.3
1987[1]	6.6	1.4	8.9	1.5
Average 1970–1979	7.4	−.0	11.3	−1.9
Average 1980–1983	7.2	−.4	10.2	−1.8
Average 1984–1987 [1]	6.6	−1.2	8.9	−2.0

[1] Estimate based on January through September 1986 compared with January through September 1987.

Source: American Hospital Association National Panel Survey.

TABLE 15.— PERCENT CHANGE IN HOSPITAL EMPLOYMENT 1980–1987

Year	Total hospital FTEs	Inpatient FTEs	Inpatient FTEs per admission
1980	4.7	4.5	1.6
1981	5.4	5.1	4.3
1982	3.7	3.4	3.4
1983	1.4	.8	1.4
1984	−2.3	−3.5	.2
1985	−2.3	−4.3	.6
1986	.3	−1.4	.7
1987 [1]	.7	−.8	.5
Average 1970–1979	4.2	2.2	1.5
Average 1980–1983	3.8	3.5	2.7
Average 1984–1987 [1]	−.9	−2.5	.5

[1] Estimate based on January through September 1986 compared with January through September 1987.

Source: American Hospital Association National Panel Survey.

REIMBURSEMENT FOR CAPITAL-RELATED EXPENSES

As described earlier in this Appendix, present law provides that capital-related costs are excluded from the prospective payment system until October 1, 1991. Until that time, capital costs continue to be reimbursed on a reasonable cost basis.

REIMBURSABLE CAPITAL EXPENSES

Reimbursable capital expenses include:

Depreciation

Depreciation is the dollar amount representing the portion of an asset's cost or value which is used up during a period of operation. Depreciation accounting is a system of accounting which prorates the cost or other basic value of a tangible capital asset, less salvage value (if any), over its estimated useful life.

An appropriate allowance for depreciation on buildings and equipment used to render care covered by Medicare is reimbursable as a capital cost. Depreciation is based on the historical, i.e., original, cost of the asset except that special rules apply in the case of assets acquired prior to 1966. The program recognizes depreciation on assets in use at the time the provider enters the program even though such assets have been fully or partially depreciated on the provider's books. A depreciation allowance is also permitted on assets that are used in a normal standby or emergency capacity or for assets financed by public funds.

In general, the useful life of an asset is based on the useful-life guidelines published by the American Hospital Association or the Internal Revenue Service. Generally, options for straight-line depreciation (which provides a uniform allowance each year) and accelerated depreciation (which permits a larger writeoff in the initial years) are permitted for assets acquired before August 1970; only straight line and (within limits) declining balance depreciation (which is one form of accelerated depreciation) are recognized for assets acquired at a later date.

Reimbursement for capital-related costs after a change of ownership is limited to the lesser of the amount that would be allowable on the purchase price or the allowable cost under Medicare to the original owner. Thus, upward revaluation of assets is no longer permitted in calculating allowable depreciation expenses. Also, transaction costs are no longer allowable costs in a resale of assets. The conference report for Public Law 98-369 also states the conferee's expectation that the Secretary will determine the reasonableness of rental costs associated with depreciable assets that have been sold in order to prevent circumvention of the revaluation restrictions by sale and lease-back arrangements.

Special rules apply with respect to gains or losses resulting from disposal of assets. In particular, when an asset is sold at a price that differs from its depreciated value, Medicare shares in the gain or loss in the same proportion as it shares in total depreciation expense. Medicare's gain (recapture) is limited to the total amount of depreciation previously paid to the seller on the asset sold. Medicare's loss is limited to its share of the asset's current depreciated value.

Medicare does not require the funding of depreciation; that is, the provider is not required to set aside the amount allowed for depreciation for replacement of the asset. However, as an incentive for funding, investment income on funded depreciation is not treated as an offset to allowable interest expense.

Public Law 97-34, the Economic Recovery Tax Act of 1981, made a number of changes in the calculation of depreciation for tax purposes. However, the law excludes Medicare (and other programs administered by HHS) from the new depreciation rules for purposes of determining cost reimbursement under the program.

Interest

Necessary and proper interest on current and capital indebtedness is included as a reimbursable capital cost under Medicare. Generally, current indebtedness represents short-term loans for working capital for normal operating expenses. Capital indebtedness represents long-term loans in which the funds are used for acquiring facilities and equipment or making capital improvements.

To be recognized as an allowable cost, interest must be incurred on funds needed to satisfy the financial needs of the hospital and must be for a purpose reasonably related to patient care. Public Law 98-369 provides that, in the case where funds are borrowed for the purchase of used assets (change of ownership), the interest expense allowable to the new owner may not exceed the amount that would be incurred by borrowing funds equal to the depreciated value of the assets on the seller's books (i.e., without revaluation).

The rate of interest may not be in excess of what a prudent borrower would have had to incur in the money market in an arm's-length transaction. The interest must be paid to a lender not related through control, ownership, or personal relationship to the borrowing organization.

Generally, allowable interest expenses are reduced by investment income except where such income is from: (1) gifts, grants, and endowments, whether restricted or unrestricted; (2) funded depreciation; (3) a provider's qualified pension fund; or (4) deferred compensation funds.

Return on equity capital of proprietary hospitals

A reasonable return on equity capital invested and used in providing patient care is an allowable cost for proprietary providers. Equity capital is the net worth of a provider excluding those assets and liabilities not related to patient care. Specifically equity capital includes: (1) a provider's investment in plant, property, and equipment (net of depreciation) related to patient care, plus funds deposited by a provider who leases such items where such deposit is required by the lease; and (2) net working capital maintained for necessary and proper operation of patient care activities.

The base amount of equity capital to be used in computing the allowable return is the average investment of the owners during a reporting period. The rate of return (for cost reporting periods on or after April 20, 1983) is equal to the rate of interest paid by the Federal Treasury on the assets of the Federal Hospital Insurance Trust Fund.

Public Law 98-369 provides that the return on equity capital on assets purchased from a previous owner (change of ownership) is limited to the amount that would be payable if the return were calculated on the depreciated value of the assets on the previous owner's books at the time of the sale.

Public Law 99-272 provided that payments to proprietary hospitals for a return on equity (ROE) will be separated from payments for other capital costs and will be phased out as follows: for hospital cost reporting periods beginning in fiscal year 1987, payment will equal 75 percent of the otherwise allowable ROE amount; for fiscal year 1988, 50 percent; for fiscal year 1989, 25 percent; and for fiscal year 1990 and thereafter, no ROE payments will be made.

Public Law 100-119 delayed the phaseout of ROE payments to proprietary hospitals, for the period from October 1, to November 20, 1987. On November 21, 1987, the phaseout of ROE payments resumed.

Table 16 shows variations in the projected level of average capital costs per case by geographic location and type of hospital for fiscal year 1988.

TABLE 16.—FISCAL YEAR 1988 CAPITAL AVERAGE COSTS PER CASE AND PERCENT DISTRIBUTION OF HOSPITALS BY CAPITAL COST PER CASE

	Average cost per case [1] [2]	Percentage distribution of hospital by capital cost per case [1]				
		0 to $149	$150 to $299	$300 to $449	$450 to $599	$600 plus
Overall total	$430	18.6	32.0	20.6	12.0	16.8
Region:						
New England	360	14.1	47.1	18.5	10.1	10.1
Middle Atlantic	423	13.0	34.9	20.0	12.8	19.3
East North Central	436	10.4	33.9	25.6	15.7	14.5
West North Central	411	28.1	38.0	16.2	9.3	8.5
South Atlantic	400	18.0	32.5	22.5	10.6	16.5
East South Central	393	25.9	30.3	19.9	9.7	14.2
West South Central	417	26.8	28.8	18.0	11.5	14.9
Mountain	463	25.9	29.5	21.7	11.1	11.8
Pacific	528	10.2	24.3	21.1	13.9	30.6
Bed size:						
0 to 99	294	32.0	38.5	13.8	6.2	9.5
100 to 299	454	7.4	27.8	25.0	15.6	24.3
300 to 499	443	2.4	21.1	31.3	25.5	19.7
500 plus	470	1.8	21.9	31.8	19.9	24.5
SMSA:						
SMSA	472	7.5	24.5	25.4	17.0	25.7
Non-SMSA	304	30.4	40.0	15.5	6.7	7.3
Teaching status:						
Major Teaching	548	6.3	21.9	23.1	20.0	28.8
Minor Teaching	458	3.2	23.3	30.9	20.5	22.0
Nonteaching	404	22.0	34.0	18.6	10.2	15.3
Ownership:						
Church	472	7.4	23.1	28.4	18.4	22.7
Government	308	34.2	39.4	15.5	6.2	4.7
Other	413	15.7	35.5	22.4	12.3	14.2
Proprietary	615	7.7	16.3	19.0	16.0	41.1

[1] Capital cost per case excluding return on equity.

[2] Average cost weighted by discharges. The unweighted average is $381.

Source: Preliminary CBO estimates using 1984 Medicare Cost File.

Table 17 shows two sets of projections of the level and the rate of increase of aggregate payments and payments per case for capital-related costs in fiscal years 1987 through 1992.

Both sets of projections for capital reflect recently enacted provisions which phase out payments for a return on equity capital for proprietary providers. The second set also includes the anticipated effects of statutory reductions in reimbursements for capital-related costs (i.e., 3.5 percent for portions of cost-reporting periods in fiscal year 1987, 12 percent for fiscal year 1988, and 15 percent for fiscal year 1989) enacted in the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509) and in the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203).

TABLE 17.—PROJECTED PAYMENTS FOR INPATIENT CAPITAL-RELATED COSTS UNDER MEDICARE'S HOSPITAL INSURANCE PROGRAM, FISCAL YEARS 1987–93[1]

	Without OBRA 1986 reductions			With OBRA 1986 reductions [2]		
	Aggregate payments (in millions of dollars)	Percent increase	Cost per case (in dollars)	Aggregate payments (in millions of dollars)	Percent increase	Cost per case (in dollars)
Fiscal year:						
1987	4,390	9.5	416	4,236	5.7	401
1988	4,807	9.5	449	4,322	2.0	404
1989	5,263	9.5	482	4,473	3.5	410
1990	5,761	9.5	516	5,761	28.8	516
1991	6,394	11.0	560	6,394	11.0	560
1992	7,098	11.0	608	7,098	11.0	608
1993	7,879	11.0	661	7,879	11.0	661

[1] Projections for capital-related payments reflect recently-enacted provisions which phase out payments for a return on equity capital for proprietary providers.

[2] Includes reductions in reimbursements enacted in the Omnibus Budget Reconciliation Act of 1986 (P.L. 99–509) and the Omnibus Budget Reconciliation Act of 1987 (P.L. 100–203) and the 1987 freeze from October 1, 1987 through November 20, 1987 (P.L. 100–119).

Source: Congressional Budget Office.

HIGHLIGHTS OF LEGISLATION AND REGULATIONS AFFECTING THE PROSPECTIVE PAYMENT SYSTEM

Medicare's Prospective Payment System (PPS) for hospitals has evolved through legislation and regulation. The original authorizing legislation, the Social Security Amendments of 1983 (P.L. 98–21), was first implemented by interim final rules issued by the Department of Health and Human Services on September 1, 1983 (48 FR 39752), and final rules issued on January 3, 1984 (49 F.R. 234).

The Deficit Reduction Act of 1984 (P.L. 98–369) made certain changes to PPS. These changes were incorporated into final rules issued by the Department on August 31, 1984 (49 F.R. 34728).

The Department issued final rules on September 3, 1985 (50 F.R. 35645) making certain changes to PPS and freezing the PPS payment rates for fiscal year 1986. However, none of the payment features of these final rules became effective.

The payment features the Department would have applied to fiscal year 1986 could not be implemented because the Emergency Extension Act of 1985 (P.L. 99-107, as amended by P.L. 99-201) extended the payment provisions that were in effect on September 30, 1985 (the final day of fiscal year 1985), through March 14, 1986. The fiscal year 1985 payment provisions were extended again, through April 30, 1986, by Public Law. 99-272. The extension of the fiscal year 1985 payment provisions into fiscal year 1986 had many effects, including a delay in the PPS transition schedule.

The Budget and Emergency Deficit Control Act of 1985 (P.L. 99-177, known as the Gramm-Rudman-Hollings Act) reduced Medicare payments to hospitals in fiscal year 1986.

Two reconciliation bills in the 99th Congress changed a number of PPS provisions. The Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272, known as COBRA) was implemented by an interim final rule on May 6, 1986 (51 F.R. 16771), and a final rule on September 3, 1986 (51 F.R. 31453). The Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509) was accompanied by a final rule on November 24, 1986 (51 F.R. 42229).

Several features of the PPS, including the calculation of the wage index, the inclusion of hospitals in Puerto Rico and alcohol and drug abuse hospitals and distinct part units in the PPS, were altered by a final regulation published on September 1, 1987 (52 FR 33034). Changes in hospital payments required by Public Law 100-119 were implemented by a final regulation published on October 23, 1987 (52 FR 39637). Regulations implementing the provisions of Public Law 100-203 (OBRA87) are expected to be issued with the proposed notice for fiscal year 1989, on or about May 1, 1988.

Legislation and regulations which changed selected features of the prospective payment system are highlighted as follows:

1. Increases in Medicare payments to hospitals

Public Law 98-21 and 49 F.R. 234: Provides that the Medicare DRG payment rates for fiscal years 1984 and 1985 would be increased annually by the increase in the hospital market basket plus 1 percentage point, subject to a budget neutrality requirement which provides that Medicare payments in those 2 years must equal what would have been spent if PPS had not been put in place. Provides that the Secretary would determine the rate of increase for fiscal year 1986 and thereafter, taking into account the recommendations of the Prospective Payment Commission.

Public Law 98-369 and 49 F.R. 34728: Changes the annual increase in the DRG payment rates for fiscal year 1985 to the increase in the market basket plus 0.25 percentage point, subject to budget neutrality. Limited the rate of increase to be determined by the Secretary for fiscal year 1986 to the rate of increase in the market basket plus 0.25 percentage point.

50 F.R. 35645: The Secretary promulgated a zero rate of increase in the DRG payment rates for fiscal year 1986.

Public Law 99-107: Provided that the payment rates in effect on September 30, 1985, would remain in effect until November 14, 1985. Public Laws 99-155, 99-181, 99-189 and 99-201 extended this requirement through March 14, 1986. (The freeze was extended through April 30, 1986, by P.L. 99-272.)

Public Law 99-177: Reduced fiscal year 1986 Medicare payments to hospitals by 1 percent beginning March 1, 1986.

Public Law 99-272, 51 F.R. 16771, and 51 F.R. 31453: Provided that the fiscal year 1986 PPS payment rates would be frozen at fiscal year 1985 levels until May 1, 1986, and would be increased ½ percent for the remainder of the year.

Public Law 99-509 and 51 F.R. 42229: Increased the payment rates for PPS hospitals by 1.15 percent in fiscal year 1987 and by the hospital market basket minus 2 percentage points in fiscal year 1988.

Public Law 100-119, 52 FR 39637: Provided an update of zero percent for the period from October 1, 1987, to November 20, 1987. The final sequester order pursuant to this legislation reduced all Medicare payments to hospitals by 2.324 percent beginning on November 21, 1987. The update of 2.7 percent mandated by Public Law 99-509 (52 FR 33034) also went into effect on November 21, 1987.

Public Law 100-203 (regulations have not been issued): required that the sequestration reduction mandated by Public Law 100-119 continue through March 31, 1988. Beginning on April 1, 1988, instead of the 2.7 percent update provided by Public Law 99-509, the PPS payment rates are increased by 3 percent for hospitals located in a rural area, by 1.5 percent for hospitals located in an urban area with a total population of more than 1 million persons (large urban areas), and by 1 percent for hospitals located in other urban areas. For fiscal year 1989, the update is equal to the increase in the market basket index minus 1.5 percentage points for hospitals located in a rural area, minus 2 percentage points for hospitals located in a large urban area, and minus 2.5 percentage points for hospitals located in other urban areas.

2. Wage index

Public Law 98-21: Provided that the Federal portion of the DRG rates be adjusted by a wage index to reflect the hospital wage level in an individual hospital's geographic area relative to the national average hospital wage level.

49 F.R. 234: The Department indicated it would use employment data from the Bureau of Labor Statistics (BLS) to develop the wage index. While acknowledging the limitations of the BLS data (including lack of information about part time employment), the Department stated that BLS data are the best presently available for the development of the wage index.

Public Law 98-369: Required the Secretary, in consultation with the Secretary of Labor, to conduct a study to develop an appropriate wage index, taking into account wage differences of full-time and part-time employees. The results of the study were to be reported to Congress by August 18, 1984. If any changes are made to the wage index as a result of this study, the Secretary is required to make retroactive adjustments to the payment amounts for hospital cost reporting periods beginning on or after October 1, 1983. Required the Secretary to study and report to Congress proposed criteria to be used to modify a hospital's wage adjustment if the hospital can demonstrate that the wage index does not accurately reflect wage levels in the labor market serving the hospital.

49 F.R. 34728: The Department indicated that it surveyed the hospitals subject to PPS to obtain wage and employment data which could be used to develop an improved wage index. However, the data obtained had too many errors to develop a reliable wage index in time for the publication of the August 1984 rules. The Department is planning to use these data, once they are determined to be accurate and reasonably complete, to conduct the mandated study and to construct a revised wage index. The Department indicated that any revised wage index will be retroactive to October 1, 1983, as mandated by law. The Department indicated that it does not intend to address the development of adjustment criteria in the near future.

50 F.R. 35645: The Department promulgated final regulations to implement the survey-based gross wage index retroactive to October 1, 1983. The survey-based wage index used to determine the amount of a hospital's underpayment or overpayment would be based on the recognized urban/rural definition in effect for the entire Federal fiscal year for which the payment adjustment determination is being made. The payment adjustments will be spread out over the course of one year, rather than requiring lump-sum payments to minimize the negative impact on overpaid hospitals.

Public Law 99-107: Provided that Medicare hospital payment amounts would be determined on the same basis as they were on September 30, 1985. Public Laws 99-155, 99-181, 99-189 and 99-201 extended this requirement through March 14, 1986. This means that there can be no change in the wage index until after this date. (This was extended through April 30, 1986, by P.L. 99-272.)

Public Law 99-272: Mandated that the gross wage index be used beginning on May 1, 1986. Also eliminated the requirement for retroactive adjustment of hospital payments.

52 F.R. 33039: Changed the method of calculating the national average wage level, and updated the wage index data. The national average wage level is now calculated by dividing national aggregate wages and salaries by the national aggregate number of paid hours of hospital employment. The Secretary also used new data; wages and salaries and paid hours of employment for hospital cost reporting periods beginning during fiscal year 1984 (the first year of the PPS). However, in order to avoid large changes in index values for individual areas, the Secretary adopted a blended wage index, which is calculated by adding together the 1982 and the 1984 index values for each area and dividing the resulting sum by 2. Wage index values for urban and rural labor market areas located in Puerto Rico are based solely on 1984 data. The new index took effect for discharges occurring on or after October 1, 1987.

Public Law 100-203; Requires the Secretary to update the wage index by October 1, 1990, and at least every 3 years thereafter. Updates are to be based on a periodic survey of the wages and wage related costs of PPS hospitals. To the extent feasible, the survey must be designed to measure earnings and hours of paid employment by occupational category, and to permit exclusion of the wages and wage related costs hospitals incur in providing skilled nursing facility services.

3. Referral centers

Public Law 98-21: Required the Secretary to provide for such exceptions and adjustments to the DRG payment amounts as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including hospitals of 500 or more beds located in rural areas).

49 F.R. 234: The Department's criteria for a referral center were that the hospital must be located in a rural area and have at least 500 beds; or the hospital must have an inpatient population such that at least 50 percent of its Medicare patients are referred from other hospitals or from physicians not on the staff of the hospital, at least 60 percent of the hospital's Medicare patients reside more than 25 miles from the hospital, and at least 60 percent of all services received by Medicare beneficiaries are provided to beneficiaries residing more than 25 miles from the hospital. Such hospitals would be paid on the basis of the higher urban rates, rather than the rural rates. No adjustment was provided for rural referral centers with fewer than 500 beds or for referral centers located in urban areas.

Public Law 98-369: Provided that a rural hospital may appeal to the Secretary to be classified as a rural referral center on the basis of criteria established by the Secretary which would allow the hospital to demonstrate that it should be so classified because it has characteristics (such as wages, scope of services, service area, and mix of medical specialties) similar to those of a typical urban hospital located in the same census region.

49 F.R. 34728: The Department broadened the definition of a rural referral center to include rural hospitals that meet a case mix index threshold, a minimum number of discharges, and one of the following three criteria: more than 50 percent of the hospital's medical staff are specialists, at least 60 percent of discharges are inpatients residing more than 25 miles from the hospital, or at least 40 percent of inpatients have been referred either from other hospitals or from physicians not on the hospital's staff.

50 F.R. 35645: The Department changed the qualifying criteria for referral centers by (1) specifying the methodology for and updating the case mix index thresholds (i.e., either the national case mix index value of 1.1294 or the median urban case mix index value for the hospital's region), and (2) specifying the threshold for the required number of discharges (i.e., either the national discharge criterion of 6,000 or the median number of urban discharges for the hospital's region).

Public Law 99-272: Reduced the requirement that a hospital have at least 6,000 or more discharges a year to 3,000, but only for osteopathic hospitals.

51 F.R. 31453: Reduced the requirement for all other hospitals to 5,369 (or a number at least equal to a specific number of discharges calculated for each census region).

Public Law 99-509: Reduced that requirement further to 5,000. Public Law 99-509 also specified that teaching hospitals should not be considered when calculating the median case mix for urban hospitals located in the same region.

52 F.R. 33034: Updated the national and regional case mix and discharge standards.

Public Law 100–203: Reduced the minimum number of beds criterion for hospitals located in a rural area, from 500 to 275, effective for discharges occurring on or after April 1, 1988. The legislation also requires the Secretary to study and report to Congress, by May 1, 1989, on (1) the referral center criteria, including, for hospitals currently designated as referral centers, the relationship of their PPS payments to their costs of inpatient care, and the appropriateness of payment on the basis of some rate other than the urban rate, and; (2) recommendations regarding criteria to be used in designating referral centers for cost reporting periods beginning on or after October 1, 1989.

4. Outliers

Public Law 98–21: Required the Secretary to provide for additional payments to hospitals for atypical cases, "outliers" whose length of stay exceeds the mean by a fixed number of days or a fixed number of standard deviations, whichever is fewer; or cases which do not meet the length of stay criteria but have charges adjusted to cost that exceed a fixed multiple of the DRG rate, or some other fixed dollar amount, whichever is greater. Provides that total outlier payments in a fiscal year must be between 5 and 6 percent of total projected DRG payments for that year.

49 F.R. 234: For fiscal year 1984, the Department defined a "day" outlier case as one for which the length of stay exceeds the average length of stay for that DRG by the lesser of 20 days or 1.94 standard deviations. The additional payment for each outlier day beyond the threshold would be 60 percent of the hospital's Federal payment amount for the DRG divided by the average length of stay for the DRG. A "cost" outlier case was defined as one for which covered charges, adjusted to operating costs, exceed the greater of 1.5 times the hospital's Federal payment amount for the DRG or $12,000. For cost outliers, the additional payment is 60 percent of the difference between the hospital's adjusted charges for the discharge and the threshold. The Department expected that under these criteria, outlier payments would approximate 6 percent of total payments to hospitals. No provision was made for outlier payments to transferring hospitals.

49 F.R. 34728: For fiscal year 1985, the Department changed the criterion for day outliers to the lesser of 22 days or 1.94 standard deviations. The criterion for cost outliers was changed to the greater of 2 times the hospital's Federal payment amount for the DRG or $13,000. The Department anticipated that these changes would reduce total outlier payments to hospitals from 6 percent to 5 percent of total DRG payments to hospitals. In addition, the Department permitted a hospital that transfers a high cost patient on or after October 1, 1984, to receive cost outlier payments.

50 F.R. 35645: For fiscal year 1986 the Department changed the criterion for day and costs outliers. If the number of days exceeds the mean length of stay for discharges within the DRG by the lesser of 17 days or 1.94 standard deviations, it would qualify as a day outlier. A discharge will be considered a high cost outlier if the cost of covered services exceeds the greater of 2.0 times the Federal rate for the DRG or $13,500. The thresholds for both day and cost outliers are still set to achieve outlier payments of 5 percent. However, this change did not go in effect because of Public Law 99-107, as amended by Public Law 99-201. In addition, medical review by a Peer Review Organization (PRO) prior to the payment of cost outlier's would no longer be required. However, if the PRO finds a hospital has a pattern of inappropriately claiming cost outliers payments, all outlier cases from that hospital would be subject to review, and the review could be conducted prior to payment until the PRO determines that appropriate corrective actions have been taken. The regulations also allow hospitals to request an outlier payment at the time they submit the bill for the discharge rather than waiting until they receive the intermediary's determination of the payment rate for the discharge.

Public Law 99-509 and 51 F.R. 42229: Established a separate urban and a separate rural set-aside factor for outliers. As a result, instead of the uniform 5 percent reduction factor applied to all of the standardized amounts, there are now two factors, one for urban standardized amounts and one for rural standardized amounts. Overall, outlier payments are required to be made at the same level as they were before this provision was enacted.

Public Law 100-203: Increased payments for outlier cases classified in DRGs relating to patients with burns from April 1, 1988, through September 30, 1989. This legislation also prohibited the Secretary from issuing any final regulations before September 1, 1988, which change the method of payment for outlier cases (other than burn cases).

5. Payment for indirect medical education

Public Law 98-21: Provided for additional payments to hospitals for the indirect costs of medical education, computed at twice the level of the educational adjustment factor provided under regulations in effect as of January 1, 1983—under the former "section 223" cost limits. The Federal portion of a hospital's DRG payments is then increased by this doubled factor.

49 F.R. 234: The educational adjustment factor in effect as of January 1, 1983 was 6.06 percent for each 0.1 increase, (above zero), in the ratio of a hospital's full-time equivalent interns and residents to its number of beds. Full-time equivalent interns and residents were defined as the sum of those employed for 35 hours or more per week, plus one-half of the total number of interns and residents working less than 35 hours per week. A hospital was allowed to count only interns and residents who were employed by and furnishing services at that hospital (excluding those employed by the hospital but furnishing services at another site).

Under PPS, the Department provided for an education adjustment factor of 11.59 percent (rather than twice the 6.06 percent factor provided in the earlier regulations). The regulations indicated that 11.59 percent was the appropriate increase after recomputing the factor using the data base on which the DRG payments were based, instead of the data base used to calculate the earlier factor. Criteria for determining which interns and residents could be counted were kept the same as in earlier regulations, except interns and residents furnishing services in the hospital but employed by an organization with a long-standing historical medical relationship with the hospital could be included.

Public Law 98-369: Provided that, effective October 1, 1984, all interns and residents who furnish services to a hospital are to be counted for purposes of determining that hospital's indirect medical education adjustment, regardless of whether or not the interns and residents are employees of that hospital.

49 F.R. 34728: To conform with the change in law, the Department indicated that it would now count full-time interns and residents on the basis of where their services were provided. When working at more than one hospital, each intern's or resident's time would be apportioned to each facility. To avoid the potential for counting interns and residents more than once, the Department is requiring hospitals to submit quarterly reports documenting the time worked by interns and residents. The final lump-sum payment for indirect medical education costs will not be made until the audit of a hospital's cost report is completed.

50 F.R. 35645: The Department changed the method used to determine the number of beds in a hospital for purposes of counting interns and residents for cost reporting periods beginning on or after October 1, 1984. In addition, the requirement that a hospital provide a quarterly report on the number of interns and residents was replaced with an annual report that counts the number of interns and residents on September 1 (with an additional count on April 15, 1985 for hospitals with cost reporting periods beginning on or after October 1, 1984 and before July 1, 1985). The requirement of counting hours of interns and residents to determine full-time equivalents was deleted. Instead, all interns and residents assigned to the hospital on September 1 (or April 15, 1985 if applicable) will be counted as full-time except for those individuals splitting their time between prospective payment areas and one or more areas excluded from PPS, or spending all their time in excluded areas. The intermediary will be required to review the hospital's documentation to verify the hospital's intern- and resident-to-bed ratio.

Public 99-272, 51 F.R. 16771, and 51 F.R. 31453: Based the additional payment to a hospital on a formula that provides an increase of approximately 8.1 percent in the Federal portion of the DRG payment, from May 1, 1986, to October 1, 1988 (when the disproportionate share adjustment was scheduled to expire). The payment increases with the ratio of a hospital's interns and residents to its bed size on a curvilinear or variable basis (i.e., the increase in the payment is less than proportional to the increase in the ratio of interns and residents to bed size). The payment adjustment after October 1, 1989, would be an increase of approximately 8.7 percent.

Public Law 99-509: Extended the disproportionate share adjustment, and the reduction in the teaching adjustment to 8.1 percent, until October 1, 1989.

Public Law 100-203: Extended the disproportionate share adjustment to October 1, 1990, and reduced the teaching adjustment factor from approximately 8.1 percent to approximately 7.7 percent, effective for discharges occurring on or after October 1, 1988,

but before October 1, 1990. The adjustment for discharges occurring on or after October 1, 1990 (when the disproportionate share adjustment expires), is also reduced from 8.7 percent to 8.3 percent.

6. Payment for nonphysician anesthetists

Public Law 98-21: Provided that all nonphysician services provided to hospital inpatients would be paid for only as hospital services under Part A of Medicare, not under Part B.

49 F.R. 234: The Department decided to allow a time-limited exception to this provision for the inpatient hospital services of anesthetists employed by physicians. For hospital cost reporting periods beginning before October 1, 1986, physicians could continue to bill Part B for the services of anesthetists if they employed anesthetists as of hospital cost reporting periods ending before September 30, 1983. The costs of these services could not be added to the hospital's base period for purposes of determining the hospital-specific portion of the payment rate during the transition period.

Public Law 98-369: For hospital cost reporting periods beginning October 1, 1984, and ending before October 1, 1987, removes from the definition of "operating costs of inpatient hospital services" the costs of anesthesia services associated with the employment of, or contracts for, certified nurse anesthetists (CNAs). Such costs will not be paid for in the DRG rates, but will be passed through and paid for on the basis of reasonable costs. Requires the Secretary to study and report to Congress as soon as is practicable possible methods of reimbursement which will not discourage the use of CRNAs by hospitals. The Conference Report for this legislation indicates that the conferees understand that the administration will modify the regulations to permit physicians who did not employ CRNAs before the specified date to bill Part B for the services of CRNAs whom they have subsequently employed; such billing will terminate on October 1, 1987, rather than October 1, 1986.

49 F.R. 34728: The Department changed the regulations to incorporate the changes made by Public Law 98-369 (as described above). In addition, the Department clarified that these provisions apply to the costs of anesthesia services provided by qualified nonphysician anesthetists, including anesthesiology assistants as well as CRNAs.

Public Law 99-509: Extended current payment provisions for the services of hospital-employed CRNAs for cost reporting periods beginning before January 1, 1989. The legislation authorized direct reimbursement to a CRNA for anesthesia services and related care which he or she is legally authorized to perform in the State. These payments would be made equal to the lower of 80 percent of actual charges or 80 percent of a fee schedule amount established by the Secretary. This provision is to be budget neutral. CRNAs would be required to accept Medicare's determination of the allowable amount (Medicare's payment plus the patient's 20 percent coinsurance amount) as payment-in-full for all Medicare services. The fee schedule would apply to services provided after January 1, 1989. Special limits on the actual charges of nonparticipating physicians for CRNA services and medical direction would apply.

7. Urban/rural boundaries

Public Law 98–21 and 49 F.R. 234: Provided that hospitals in urban areas are paid different Federal DRG rates than hospitals located in rural areas. Urban areas are defined as those located within a Metropolitan Statistical Area (MSA) or a New England County Metropolitan Area (NECMA). Rural areas are those not classified as urban areas. Provided that during a 3-year transition period, hospitals are paid on the basis of Federal DRG payment amounts calculated separately for each of the nine census regions of the country.

Public Law 98–369: Provided that hospitals located in an MSA that crosses census region boundaries be deemed to be in the region in which a majority of the hospitals in that MSA are located or, at the option of the Secretary, the region from which the majority of the Medicare inpatient discharges within that MSA are made. In addition, provided that hospitals located in counties redesignated from urban to rural because of a change in the MSA or NECMA classification system since April 20, 1983, are allowed a 2-year transition to the lower rural payment rates. In the first hospital cost reporting period, the hospital would be paid the rural rate plus two-thirds of the difference between its rural and urban rates. In the second year, it would be paid the rural rate plus one-third of the difference between its rural and urban rates.

49 FR 34728: The Department changed the regulations to conform to the changes in Public Law 98–369 (as described above). However, in determining the appropriate region for hospitals in MSA's which cross more than one region's boundaries, the Department chose not to use the criterion of the number of Medicare inpatient discharges. Also, if an equal number of hospitals within the MSA are located in each census region, the Department provided that such hospitals will be deemed to be in the census region with the higher Federal rate.

Public Law 100–203: Changes the standards for including a rural county adjacent to an urban area in the definition of the urban area. If (1) at least 15 percent of employed residents of the rural county commute to one or more adjacent urban areas for employment, or (2) the sum of the number of county residents commuting to all adjacent urban areas plus the number of residents of all adjacent urban areas commuting to the rural county for employment, is at least equal to 20 percent of the employed population of the county, then the rural county would be included in the definition of the urban area to which the greatest number of its residents commute.

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ADDITIONAL HOSPITAL DATA

The following tables present a variety of data which may be useful in understanding Medicare's hospital reimbursement system.

Table 18 illustrates the complete list of DRGs, the relative resource consumption associated with each DRG as illustrated by each DRG's weight, and the change in the weight from fiscal year 1987 to fiscal year 1988. Table 19 presents the distribution of percent changes in the weights.

Tables 20 and 21 display Medicare hospital payments by type, size, and location of hospital. Table 22 displays hospital payments by the components of Medicare reimbursement: basic payment, day and cost outlier payments, indirect teaching payments, disproportionate share payments, and transfer payments.

Table 23 displays summary characteristics of hospitals participating in the Medicare program.

TABLE 18.—LIST OF DIAGNOSIS RELATED GROUPS (DRG'S), FISCAL YEARS 1987 AND 1988 RELATIVE WEIGHTING FACTORS AND THE PERCENTAGE CHANGE, AVERAGE LENGTH OF STAY, AND OUTLIER THRESHOLD USED IN THE PROSPECTIVE PAYMENT SYSTEM

DRG	MDC	Type	Title	Relative weighting factors			Arithmetic mean length of stay	Outlier threshold
				1987	1988	Percent change, 1987–88		
1	1	Surg	Craniotomy age greater than 17 except for trauma	3.5610	3.4434	—3.3	18.8	32
2	1	Surg	Craniotomy for trauma age greater than 17	3.8111	3.8160	.1	18.3	31
3	1	Surg	Craniotomy age 0–17	2.9183	2.9183	0	NA	31
4	1	Surg	Spinal procedures	2.7296	2.5904	—5.1	16.9	30
5	1	Surg	Extracranial vascular procedures	1.6508	1.5685	—5.0	8.0	21
6	1	Surg	Carpal tunnel release	.4073	.4393	7.9	2.6	7
7	1	Surg	Periph and cranial nerve and other nerv syst proc with CC	1.3866	2.5269	82.2	20.3	29
8	1	Surg	Periph and cranial nerve and other nerv syst proc without CC.	.7464	.7367	—1.3	5.1	19
9	1	Med	Spinal disorders and injuries	1.4235	1.2639	—11.2	11.1	25
10	1	Med	Nervous system neoplasms with CC	1.1322	1.2123	7.1	11.2	26
11	1	Med	Nervous system neoplasms without CC	.9338	.7729	—17.2	7.6	23
12	1	Med	Degenerative nervous system disorders	1.0001	.9459	—5.4	9.9	25
13	1	Med	Multiple sclerosis and cerebellar ataxia	.9790	9324	—4.8	9.6	25
14	1	Med	Specific cerebrovascular disorders except TIA	1.3143	1.2429	—5.4	10.5	25
15	1	Med	Transient ischemic attack and precerebral occlusions	.6241	.6293	.8	5.4	17
16	1	Med	Nonspecific cerebrovascular disorders with CC	.9042	1.0384	14.8	9.0	25
17	1	Med	Nonspecific cerebrovascular disorders without CC	.6802	.6358	—6.5	6.0	20
18	1	Med	Cranial and peripheral nerve disorders with CC	.7566	.9557	26.3	8.5	24
19	1	Med	Cranial and peripheral nerve disorders without CC	.6549	.6158	—6.0	6.0	22
20	1	Med	Nervous system infection except viral meningitis	1.4087	1.6220	15.1	11.2	26
21	1	Med	Viral meningitis	1.3143	1.3613	3.6	9.2	25
22	1	Med	Hypertensive encephalopathy	.7086	.7055	—.4	5.8	18

23	1	Med	Nontraumatic stupor and coma	1.1239	.9505	–15.4	6.7	22
24	1	Med	Seizure and headache age greater than 17 with CC	.7642	.9228	20.8	7.0	23
25	1	Med	Seizure and headache age greater than 17 without CC	.5520	.5386	–2.4	4.6	15
26	1	Med	Seizure and headache age 0–17	.6255	.5635	–9.9	3.6	13
27	1	Med	Traumatic stupor and coma, coma greater than 1 HR	1.5645	1.4753	–5.7	8.7	22
28	1	Med	Traumatic stupor and coma, coma greater than 1 HR age greater than 17 with CC.	.9422	1.1694	24.1	8.9	24
29	1	Med	Traumatic stupor and coma, coma less than 1 HR age greater than 17 without CC.	.6462	.5856	–9.4	5.2	20
30	1	Med	Traumatic stupor and coma, coma less than 1 HR age 0–17.	.3539	.3539	0	NA	8
31	1	Med	Concussion age greater than 17 with CC	.5381	.6550	21.7	6.0	22
32	1	Med	Concussion age greater than 17 without CC	.4064	.4005	–1.5	3.7	13
33	1	Med	Concussion age 0–17	.2457	.2457	0	NA	5
34	1	Med	Other disorders of nervous system with CC	.9761	1.2038	23.3	8.7	24
35	1	Med	Other disorders of nervous system without CC	.7383	.6035	–18.3	5.6	21
36	2	Surg	Retinal procedures	.7101	.6820	–4.0	3.6	10
37	2	Surg	Orbital procedures	.6687	.7104	6.2	4.1	14
38	2	Surg	Primary iris procedures	.3963	.3779	–4.6	2.8	9
39	2	Surg	Lens procedures with or without vitrectomy	.5719	.5167	–9.7	2.1	5
40	2	Surg	Extraocular procedures except orbit age greater than 17	.4133	.4675	13.1	2.6	7
41	2	Surg	Extraocular procedures except orbit age 0–17	.3657	.3657	0	NA	4
42	2	Surg	Intraocular procedures retina, iris and lens	.6542	.6600	.9	3.1	9
43	2	Med	Hyphema	.3461	.3727	7.7	4.5	14
44	2	Med	Acute major eye infections	.6395	.6352	–.7	6.8	20
45	2	Med	Neurological eye disorders	.5407	.5595	3.5	4.3	14
46	2	Med	Other disorders of the eye age greater than 17 with CC	.6009	.6195	3.1	5.6	22
47	2	Med	Other disorders of the eye age greater than 17 without CC.	.4187	.3611	–13.8	3.6	13
48	2	Med	Other disorders of the eye age 0–17	.4018	.4018	0	NA	13
49	3	Surg	Major head and neck procedures	2.8742	2.8923	.6	15.7	30

TABLE 18.—LIST OF DIAGNOSIS RELATED GROUPS (DRG'S), FISCAL YEARS 1987 AND 1988 RELATIVE WEIGHTING FACTORS AND THE PERCENTAGE CHANGE, AVERAGE LENGTH OF STAY, AND OUTLIER THRESHOLD USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

DRG	MDC	Type	Title	Relative weighting factors			Arithmetic mean length of stay	Outlier threshold
				1987	1988	Percent change, 1987–88		
50	3	Surg	Sialoadenectomy	.7033	.6681	−5.0	3.4	9
51	3	Surg	Salivary gland procedures except staloadenectomy	.5878	.5424	−7.7	2.9	8
52	3	Surg	Cleft lip and palate repair	.6955	.7033	1.1	3.5	11
53	3	Surg	Sinus and mastoid procedures age greater than 17	.6175	.6159	−0.3	3.1	10
54	3	Surg	Sinus and mastoid procedures age 0–17	.6889	.6889	0	NA	11
55	3	Surg	Miscellaneous ear, nose and throat procedures	.4342	.4598	5.9	2.3	6
56	3	Surg	Rhinoplasty	.4357	.4471	2.6	2.4	7
57	3	Surg	T&A proc, except tonsillectomy and/or adendidectomy only, age greater than 17.	.7717	.7907	2.5	5.1	20
58	3	Surg	T&A proc, except tonsillectomy and/or adenidiectomy only, age 0–17.	.3097	.3097	0	NA	3
59	3	Surg	Tonsillectomy and/or adenoidectomy only, age greater than 17.	.4130	.3845	−6.9	2.0	5
60	3	Surg	Tonsillectomy and/or adenoidectomy only, age 0–17	.2616	.2616	0	NA	3
61	3	Surg	Myringotomy with tube insertion age greater than 17	.4273	.5401	26.4	3.2	11
62	3	Surg	Myringotomy with tube insertion age 0–17	.3089	.3089	0	NA	3
63	3	Surg	Other ear, nose and throat O.R. procedures	1.1618	1.1538	−0.7	7.4	23
64	3	Med	Ear, nose and throat malignacy	.9769	1.0548	8.0	8.5	23
65	3	Med	Dysequlibrium	.4500	.4600	2.2	4.2	12
66	3	Med	Epistaxis	.4144	.4272	3.1	3.9	12
67	3	Med	Epiglottitis	.9363	.9964	6.4	5.8	19
68	3	Med	Otitis media and uri age greater than 17 with CC	.6088	.7217	18.5	6.1	17
69	3	Med	Otitis media and uri age greater than 17 without CC	.5040	.5366	6.5	4.9	14
70	3	Med	Otitis media and uri age 0–17	.5251	.5345	1.8	4.0	13

71	3	Med	Laryngotracheitis	.6582	.6026	−8.4	4.7	14
72	3	Med	Nasal trauma and deformity	.5216	.4895	−6.2	4.3	15
73	3	Med	Other ear, nose and throat diagnoses age greater than 17	.6045	.7404	22.5	5.6	22
74	3	Med	Other ear, nose and throat diagnoses age 0–17	.3427	.3427	0	NA	9
75	4	Surg	Major chest procedures	2.9776	3.0258	1.6	14.9	30
76	4	Surg	Other resp system O.R. procedures with CC	2.5663	2.0885	−18.6	12.6	27
77	4	Surg	Other resp system O.R. procedures without CC	1.6734	1.0970	−34.4	6.8	22
78	4	Med	Pulmonary embolism	1.4798	1.4817	.1	10.8	27
79	4	Med	Respiratory infections and inflammations age greater than 17 with CC.	1.9344	2.0777	7.4	12.8	28
80	4	Med	Respiratory infections and inflammations age greater than 17 without CC.	1.4387	1.3341	−7.3	9.7	26
81	4	Med	Respiratory infections and inflammations age 0–17	.8652	1.1032	27.5	9.5	25
82	4	Med	Respiratory neoplasms	1.1258	1.1899	5.7	9.3	24
83	4	Med	Major chest trauma with CC	.8397	.9698	15.5	8.4	25
84	4	Med	Major chest trauma without CC	.5920	.5372	−9.3	5.4	17
85	4	Med	Pleural effusion with CC	1.1196	1.1451	2.3	9.0	25
86	4	Med	Pleural effusion without CC	.9761	.7720	−20.9	6.6	23
87	4	Med	Pulmonary edema and respiratory failure	1.8076	1.5691	−13.2	8.4	24
88	4	Med	Chronic obstructive pulmonary disease	1.0768	1.1263	4.6	7.9	24
89	4	Med	Simple pneumonia and pleurisy age greater than 17 with CC.	1.1657	1.2862	10.3	9.2	25
90	4	Med	Simple pneumonia and pleurisy age greater than 17 without CC.	.8842	.8961	1.3	7.1	19
91	4	Med	Simple pneumonia and pleurisy age 0–17	.7914	.9448	19.4	6.3	23
92	4	Med	Interstitial lung disease with CC	1.1115	1.2821	15.3	8.9	25
93	4	Med	Interstitial lung disease without CC	.8641	.8264	−4.4	6.6	23
94	4	Med	Pneumothorax with CC	1.3044	1.3954	7.0	9.7	25
95	4	Med	Pneumothorax without CC	.8796	.7571	−13.9	6.5	21
96	4	Med	Bronchitis and asthma age greater than 17 with CC	.8446	.9804	16.1	7.2	20

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DRG	MDC	Type	Title	Relative weighting factors			Arithmetic mean length of stay	Outlier threshold
				1987	1988	Percent change, 1987–88		
97	4	Med	Bronchitis and asthma age greater than 17 without CC	.7091	.7151	.8	5.7	15
98	4	Med	Bronchitis and asthma age 0–17	.7201	.5744	−20.2	3.7	11
99	4	Med	Respiratory signs and symptoms with CC	.8072	.7803	−3.3	5.6	19
100	4	Med	Respiratory signs and symptoms without CC	.6253	.5238	−16.2	3.6	11
101	4	Med	Other respiratory system diagnoses with CC	.8460	.9585	13.3	7.1	23
102	4	Med	Other respiratory system diagnoses without CC	.6841	.6625	−3.2	5.3	19
103	5	Surg	Heart transplant	.0000	11.9225	NA	33.3	44
104	5	Surg	Cardiac value procedure with pump and with cardiac cath	7.3151	7.3424	.4	20.4	35
105	5	Surg	Cardiac value procedure with pump and without cardiac cath.	6.3388	5.7811	−8.8	15.8	31
106	5	Surg	Coronary bypass with cardiac cath	5.3324	5.5415	3.9	16.0	32
107	5	Surg	Coronary bypass without cardiac cath	4.6608	4.2858	−8.0	12.6	29
108	5	Surg	Other cardiothoracic or vascular procedures, with pump	4.7803	5.3703	12.3	15.7	29
109	5	Surg	Other cardiothoracic procedures without pump	4.3579	3.9142	−10.2	12.3	25
110	5	Surg	Major reconstructive vascular proc without pump with CC	3.3118	3.6718	10.9	16.1	31
111	5	Surg	Major reconstructive vascular proc without pump without CC.	2.4549	2.2639	−7.8	10.6	27
112	5	Surg	Vascular procedures except major reconstruciton without pump.	2.2055	1.8911	−14.3	8.2	24
113	5	Surg	Amputation for circ system disorders except upper limb and toe.	2.5345	2.4590	−3.0	18.8	33
114	5	Surg	Upper limb and toe amputation for circ system disorders	1.8918	1.7040	−9.9	14.0	28
115	5	Surg	Perm cardiac pacemaker implant with ami, heart failure or shock.	4.1727	4.0516	−2.9	15.2	31

116	5	Surg	Perm cardiac pacemarker implant without ami heart failure or shock.	2.9868	2.7694	−7.3	8.3	25
117	5	Surg	Cardiac pacemaker replace and revis except pulse gen replacement.	1.2989	1.2261	−5.6	6.2	22
118	5	Surg	cardiac pacemaker pulse generator replacement	1.9224	1.7563	−8.6	4.1	14
119	5	Surg	Vein ligation and stripping	.9164	.8692	−5.2	6.3	22
120	5	Surg	Other circulatory system O.R. procedures	2.2577	2.4776	9.7	16.6	29
121	5	Med	Circulatory disorders with ami and C.V. comp, disch alive	1.7687	1.7162	−3.0	11.2	27
122	5	Med	Circulatory disorders without ami without C.V. comp, disch alive.	1.3267	1.2002	−9.5	8.7	25
123	5	Med	Circulatory disorders without ami, expired	1.3522	1.3979	3.4	5.3	21
124	5	Med	Circulatory disorders except ami, with card cath and complex diag.	1.2551	1.1806	−5.9	6.2	22
125	5	Med	Circulatory disorders except ami, with card cath without complex diag.	.7265	.6884	−5.2	3.2	10
126	5	Med	Acute and subacute endocarditis	2.9836	3.0575	2.5	22.7	35
127	5	Med	Heart failure and shock	1.0098	1.0222	1.2	7.9	24
128	5	Med	Deep vein thromophlebitis	.8456	.8513	.7	9.1	22
129	5	Med	Cardiac arrest, unexplained	1.7199	1.5715	−8.6	5.9	21
130	5	Med	Peripheral vascular disorders with CC	.8251	.8776	6.4	7.8	24
131	5	Med	Peripheral vascular disorders without CC	.6705	.5862	−12.6	5.6	22
132	5	Med	Atherosclerosis with CC	.8037	.7976	−.8	6.0	19
133	5	Med	Atherosclerosis without CC	.7049	.5997	−14.9	4.6	14
134	5	Med	Hypertension	.6363	.6088	−4.3	5.5	17
135	5	Med	Cardiac congenital and valvular disorders age greater than 17 with CC.	.8937	.9221	3.2	7.0	23
136	5	Med	Cardiac congenital and valvular disorders age greater than 17 without CC.	.7525	.6103	−18.9	4.8	15
137	5	Med	Cardiac congenital and valvular disorders age 0–17	.6315	.6315	0	NA	21
138	5	Med	Cardiac arrhythmia and conduction disorders with CC	.8136	.8535	4.9	6.2	20
139	5	Med	Cardiac arrhythmia and conduction disorders without CC	.6514	.5912	−9.2	4.5	14

TABLE 18.—LIST OF DIAGNOSIS RELATED GROUPS (DRG'S), FISCAL YEARS 1987 AND 1988 RELATIVE WEIGHTING FACTORS AND THE PERCENTAGE CHANGE, AVERAGE LENGTH OF STAY, AND OUTLIER THRESHOLD USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

DRG	MDC	Type	Title	Relative weighting factors			Arithmetic mean length of stay	Outlier threshold
				1987	1988	Percent change, 1987–88		
140	5	Med	Angina pectoris	.6894	.6689	−3.0	5.0	14
141	5	Med	Syncope and collapse with CC	.6187	.6801	9.9	5.5	17
142	5	Med	Syncope and Collapse without CC	.5335	.5244	−1.7	4.2	13
143	5	Med	Chest pain	.5893	.5500	−6.7	3.7	11
144	5	Med	Other circulatory system diagnoses with CC	1.1160	1.1449	2.6	7.8	24
145	5	Med	Other circulatory system diagnoses without CC	.8475	.6689	−21.1	5.0	17
146	6	Surg	Rectal resection with CC	3.0751	3.4379	11.8	18.0	34
147	6	Surg	Rectal resection without CC	2.2735	2.1344	−6.1	13.0	27
148	6	Surg	Major small and large bowel procedures with CC	2.9401	3.2376	10.1	17.1	33
149	6	Surg	Major small and large bowel procedures without CC	2.1069	1.8341	−12.9	11.6	24
150	6	Surg	Peritoneal adhesiolysis with CC	2.3426	2.6797	14.4	15.0	31
151	6	Surg	Peritoneal adhesiolysis without CC	1.5900	1.4885	−6.4	10.0	24
152	6	Surg	Minor small and large bowel procedures with CC	1.4059	1.5988	13.7	10.6	26
153	6	Surg	Minor small and large bowel procedures without CC	1.0992	1.0566	−3.9	7.8	23
154	6	Surg	Stomach, esophageal and duodenal procedures age greater than 17 with CC.	2.6876	3.7961	41.2	17.4	31
155	6	Surg	Stomach, esophageal and duodenal procedures age greater than 17 without CC.	1.7902	1.8195	1.6	10.8	27
156	6	Surg	Stomach, esopohageal and duodenal procedures age 0–17	.8382	.8382	0	NA	21
157	6	Surg	Anal and stomal procedures with CC	.7302	.9324	27.7	7.0	23
158	6	Surg	Anal and stomal procedures without CC	.5511	.5449	−1.1	4.2	13
159	6	Surg	Hernia procedures except inguinal and femoral age greater than 17 with CC.	.9997	1.1454	14.6	7.5	23

160	6	Surg	Hernia procedures except inguinal and femoral age greater than 17 without CC.	.7457	.6810	−8.7	4.7	14
161	6	Surg	Inguinal and femoral hernia procedures age greater than 17 with CC.	.6536	.7541	15.4	5.1	16
162	6	Surg	Inguinal and femoral hernia procedures age greater than 17 without CC.	.5261	.5004	−4.9	3.3	9
163	6	Surg	Hernia procedures age 0–17	.9647	.7717	−20.0	4.4	11
164	6	Surg	Appendectomy with complicated principal diag with CC	2.0646	2.4014	16.3	12.6	29
165	6	Surg	Appendectomy with complicated principal diag without CC	1.4375	1.4675	2.1	8.7	18
166	6	Surg	Appendectomy without complicted principal diag with CC	1.3604	1.4954	9.9	8.8	23
167	6	Surg	Appendectomy without complicated principal dial without CC.	.8872	.8651	−2.5	5.4	12
168	6	Surg	Mouth procedures with CC	.9182	1.4067	53.2	8.2	23
169	6	Surg	Mouth procedures without CC	.6580	.6689	1.7	3.6	12
170	6	Surg	Other digestive system O.R. procedures with CC	2.7611	2.7316	−1.1	16.2	29
171	6	Surg	Other digestive system O.R. procedures without CC	2.3295	1.4018	−39.8	9.4	25
172	6	Med	Digestive malignancy with CC	1.0748	1.1861	10.4	10.3	25
173	6	Med	Digestive malignancy without CC	.9602	.7049	−26.6	6.6	22
174	6	Med	G.I. hemorrhage with CC	.9073	.9878	8.9	7.1	22
175	6	Med	G.I. hemorrhage without CC	.7067	.6600	−6.6	5.3	15
176	6	Med	Complicated peptic ulcer	.9316	.9964	7.0	7.8	24
177	6	Med	Uncomplicated peptic ulcer with CC	.6615	.7834	18.4	6.5	18
178	6	Med	Uncomplicated peptic ulcer without CC	.5554	.5838	5.1	5.1	14
179	6	Med	Inflammatory bowel disease	.9875	1.0416	5.5	9.1	25
180	6	Med	G.I. obstruction with CC	.7583	.9150	20.7	7.6	24
181	6	Med	G.I. obstruction without CC	.5827	.5415	−7.1	5.1	16
182	6	Med	Esophagitis, gastroent and misc digest disorders age greater than 17 with CC.	.6032	.7224	19.8	6.2	19
183	6	Med	Esophagitis, gastroent and misc digest disorders age greater than 17 without CC.	.5104	.5252	2.9	4.6	14
184	6	Med	Esophagitis, gastroent and misc digest disorders age 0–17.	.4828	.4223	−12.5	3.5	13

TABLE 18.—LIST OF DIAGNOSIS RELATED GROUPS (DRG'S), FISCAL YEARS 1987 AND 1988 RELATIVE WEIGHTING FACTORS AND THE PERCENTAGE CHANGE, AVERAGE LENGTH OF STAY, AND OUTLIER THRESHOLD USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

DRG	MDC	Type	Title	Relative weighting factors 1987	1988	Percent change, 1987–88	Arithmetic mean length of stay	Outlier threshold
185	6	Med	Dental and oral dis except extractions and restorations, age greater than 17.	.7147	.7530	5.4	6.4	22
186	6	Med	Dental and oral dis except extractions and restorations, age 0–17.	.4112	.4112	0	NA	11
187	6	Med	Dental extractions and restorations	.4209	.4540	7.9	2.8	8
188	6	Med	Other digestive system diagnoses age greater than 17 with CC.	.7171	.9144	27.5	6.9	23
189	6	Med	Other digestive system diagnoses age greater than 17 without CC.	.5260	.4966	−5.6	4.2	15
190	6	Med	Other digestive system diagnoses age 0–17	.9178	.8147	−11.2	4.9	15
191	7	Surg	Major pancreas, liver and shunt procedures	4.4603	4.6881	5.1	20.7	35
192	7	Surg	Minor pancreas, liver and shunt procedures	4.0437	3.8625	−4.5	19.5	32
193	7	Surg	Biliary tract proc except tot cholecystectomy with CC	2.8115	3.0252	7.6	17.5	32
194	7	Surg	Biliary tract proc except tot cholecystectomy without CC	2.1204	1.8505	−12.7	12.3	28
195	7	Surg	Total cholecystectomy with c.d.e. with CC	2.2724	2.3854	5.0	13.9	30
196	7	Surg	Total cholecystectomy with c.d.e. without CC	1.5974	1.6898	5.8	10.8	22
197	7	Surg	Total cholecystectomy without c.d.e. with CC	1.7055	1.8768	10.0	11.2	27
198	7	Surg	Total cholecystectomy without c.d.e. without CC	1.1399	1.1152	−2.2	7.5	15
199	7	Surg	Hepatobiliary diagnostic procedure for malignancy	2.3379	2.2693	−2.9	15.3	30
200	7	Surg	Hepatobiliary diagnostic procedure for non-malignancy	2.6281	2.4731	−5.9	13.5	27
201	7	Surg	Other hepatobiliary or pancreas o.r. procedures	2.7125	2.3933	−11.8	12.8	26
202	7	Med	Cirrhosis and alcoholic hepatitis	1.1665	1.2075	3.5	9.9	25
203	7	Med	Malignancy of hepatobiliary system or pancreas	1.0338	1.0422	.8	9.3	24

204	7	Med	Disorders of pancreas except malignancy	.9698	1.0269	5.9	7.7	24
205	7	Med	Disorders of liver except malig, cirr, alc hepa with CC	1.0718	1.2132	13.2	9.3	25
206	7	Med	Disorders of liver except malig, cirr, alc hepa without CC	.7735	.6806	−12.0	6.0	22
207	7	Med	Disorders of the biliary tract with CC	.7775	.9243	18.9	7.1	23
208	7	Med	Disorders of the biliary tract without CC	.8793	.5816	−33.9	4.7	15
209	8	Surg	Major joint and limb reattachment procedures	2.3925	2.4145	.9	13.4	28
210	8	Surg	Hip and femur procedures except major joint age greater than 17 with CC.	2.0317	2.1776	7.2	15.8	32
211	8	Surg	Hip and fermur procedures except major joint age greater than without CC.	1.7866	1.6104	−9.9	12.3	27
212	8	Surg	Hip and femur procedures except major joint age 0–17	1.6608	1.3764	−17.1	7.2	17
213	8	Surg	Amputation for musculoskeletal system and conn tissue disorders.	1.9750	1.8460	−6.5	14.3	29
214	8	Surg	Back and neck procedures with CC	1.8749	2.1385	14.1	15.3	31
215	8	Surg	Back and neck procedures without CC	1.4275	1.3768	−3.6	10.3	26
216	8	Surg	Biopsies of musceloskeletal system and connective tissue	1.5565	1.5973	2.6	13.0	26
217	8	Surg	Wnd debrid and skn grft exept hand, for muscskelet and tiss dis.	2.3097	2.8155	21.9	20.6	31
218	8	Surg	Lower extrem and humer proc except hip, foot, femur age greater than with CC.	1.3797	1.6224	17.6	11.5	27
219	8	Surg	Lower extrem and humer proc except hip, foot, femur age greater than without CC.	1.0436	1.0186	−2.4	7.1	20
220	8	Surg	Lower extrem and humer proc except hip, foot, femur age 0–17.	.9242	.9242	0	NA	23
221	8	Surg	Knee procedures with CC	1.0141	1.4523	43.2	9.5	24
222	8	Surg	Knee procedures without CC	.7262	.7995	10.1	4.7	18
223	8	Surg	Major shoulder or elbow proc, or other upper extremity proc, with CC.	1.2263	1.1202	−8.7	6.9	22
224	8	Surg	Shoulder, elbow or forearm proc, exc major joint proc, without CC.	.6894	.6588	−4.4	3.9	12

TABLE 18.—LIST OF DIAGNOSIS RELATED GROUPS (DRG'S), FISCAL YEARS 1987 AND 1988 RELATIVE WEIGHTING FACTORS AND THE PERCENTAGE CHANGE, AVERAGE LENGTH OF STAY, AND OUTLIER THRESHOLD USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

DRG	MDC	Type	Title	Relative weighting factors			Arithmetic mean length of stay	Outlier threshold
				1987	1988	Percent change, 1987–88		
225	8	Surg	Foot procedures	.6552	.6775	3.4	4.3	14
226	8	Surg	Soft tissue procedures with CC	.8783	1.3570	54.5	10.1	25
227	8	Surg	Soft tissue procedures without CC	.6673	.6878	3.1	4.6	16
228	8	Surg	Major thumb or joint proc, or oth hand or wrist proc, with CC.	.6100	.8201	34.4	4.3	14
229	8	Surg	Hand or wrist proc, except major joint proc, without CC	.4993	.5202	4.2	2.7	8
230	8	Surg	Local excision and removal of int fix devices of hip and femur.	1.0156	.8868	−12.7	6.7	23
231	8	Surg	Local excision and removal of int fix devices except hip and fermur.	.7381	.8346	13.1	5.5	21
232	8	Surg	Arthroscopy	.6723	.8603	28.0	5.3	21
233	8	Surg	Other musculoskelet sys and conn tiss O.R. proc with CC	1.3898	1.7267	24.2	12.5	27
234	8	Surg	Other musculoskelet sys and conn tiss O.R. proc without CC.	.9517	.9057	−4.8	6.5	23
235	8	Med	Fractures of femur	1.4136	1.2060	−14.7	13.9	26
236	8	Med	Fractures of hip and pelvis	1.0712	.9036	−15.6	10.1	25
237	8	Med	Sprains, strains, and dislocations of hip, pelvis and thigh	.6049	.5959	−1.5	6.4	23
238	8	Med	Osteomyelitis	1.6471	1.6579	.7	14.6	29
239	8	Med	Pathological fractures and musculoskeletal and conn tiss malignancy.	.9268	.9550	3.0	9.9	26
240	8	Med	Connective tissue disorders with CC	.9047	1.0932	20.8	9.5	25
241	8	Med	Connective tissue disorders without CC	.7463	.6644	−11.0	6.9	22
242	8	Med	Septic arthritis	1.4562	1.4100	−3.2	11.6	27
243	8	Med	Medical back problems	.6840	.6694	−2.1	6.9	23

244	8	Med	Bone diseases and specific arthropathies with CC	.6742	.7305	8.4	7.5	24
245	8	Med	Bone diseases and specific arthropathies without CC	.6400	.5345	−16.5	5.6	19
246	8	Med	Non-specific arthopathies	.5935	.5769	−2.8	5.8	18
247	8	Med	Signs and symptoms of musculoskeletal system and conn tissue.	.5793	.5407	−6.7	5.1	18
248	8	Med	Tendonitis myositis and bursitis	.5892	.6097	3.5	5.8	19
249	8	Med	Aftercare musculoskeletal system and connective tissue	.7875	.6830	−13.3	6.8	22
250	8	Med	Fx, sprn, strans and disl of forearm hand foot age greater than with CC.	.5158	.6721	30.3	6.3	22
251	8	Med	Fx, sprn, strans and disl of froearm hand foot age greater than without CC.	.4003	.4148	3.6	3.4	11
252	8	Med	Fx, sprn, strans and disl of uparm lowleg ex foot age 0–17.	.3496	.3496	0	NA	7
253	8	Med	Fx, sprn, strns and disl of wparm lowleg ex foot age greater than with CC.	.6321	.7909	25.1	8.3	24
254	8	Med	Fx, sprn, strans and of wparm lowleg ex foot age greater than without CC.	.4929	.4557	−7.5	5.1	18
255	8	Med	Fx, sprn, strns and disl or uparm lowleg ex foot age 0–17	.4638	.4638	0	NA	15
256	8	Med	Other musculoskeletal system and connective tissue diagnoses.	.6991	.6585	−5.8	5.8	21
257	9	Surg	Total mastectomy for malignancy with CC	1.0630	1.0448	−1.7	7.4	18
258	9	Surg	Total mastectomy for malignancy without CC	.9696	.8462	−12.7	5.9	13
259	9	Surg	Subtotal mastectomy for malignancy with CC	.8605	1.0046	16.7	7.4	23
260	9	Surg	Subtotal mastectomy for malignancy without CC	.6659	.6010	−9.7	3.6	11
261	9	Surg	Breast proc for non-malignancy except biopsy and local excision.	.6104	.6204	1.6	3.3	9
262	9	Surg	Surg Breast biopsy and local excision for non/malignancy	.4252	.4312	1.4	2.4	6
263	9	Surg	Skin graft and or debrid for skn ulcer or cellulitis with CC	2.4173	2.5967	7.4	20.8	33
264	9	Surg	Skin graft and or debrid for skn ulcer or cellulitis without CC.	2.1798	1.6179	−25.8	14.7	29
265	9	Surg	Skin craft and or debrid except for skin ulcer or cellulitis with CC.	1.3967	1.3909	−.4	10.5	25

TABLE 18.—LIST OF DIAGNOSIS RELATED GROUPS (DRG'S), FISCAL YEARS 1987 AND 1988 RELATIVE WEIGHTING FACTORS AND THE PERCENTAGE CHANGE, AVERAGE LENGTH OF STAY, AND OUTLIER THRESHOLD USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

DRG	MDC	Type	Title	Relative weighting factors			Arithmetic mean length of stay	Outlier threshold
				1987	1988	Percent change, 1987–88		
266	9	Surg	Skin graft and debrid except for skin ulcer or cellulitis without CC.	.7313	.6865	−6.1	4.9	19
267	9	Surg	Perianal and pilonidal procedures	.6360	.6248	−1.8	4.6	15
268	9	Surg	Skin, subcutaneous tissue and breast plastic procedures	.5657	.5934	4.9	3.5	12
269	9	Surg	Other skin, subcut tiss and breast O.R. proc with CC	1.1334	1.5177	33.9	11.5	26
270	9	Surg	Other skin, subcut tiss and breast O.R. proc without CC	.7622	.6834	−10.3	4.9	18
271	9	Med	Skin ulcers	1.2612	1.2017	−4.7	11.5	27
272	9	Med	Major skin disorders with CC	.8524	1.0375	21.7	9.7	25
273	9	Med	Major skin disorders without CC	.7971	.7247	−9.1	7.9	24
274	9	Med	Malignant breast disorders with CC	1.0367	1.0494	1.2	9.9	24
275	9	Med	Malignant breast disorders without CC	.9880	.6395	−35.3	6.1	22
276	9	Med	Non-malignat breast disorders	.5677	.5245	−7.6	4.3	16
277	9	Med	Cellulitis age greater than with CC	.8861	.9695	9.4	8.8	25
278	9	Med	Cellulitis age greater than without CC	.7582	.7063	−6.8	6.9	19
279	9	Med	Cellulitis age 0–17	.4739	.7367	55.5	5.4	16
280	9	Med	Trauma to the skin, subcut tiss and breast age greater than with CC.	.5414	.6197	14.5	6.1	22
281	9	Med	Trauma to the skin subcut tiss and breast age greater than 17 without CC.	.4467	.4306	−3.6	4.5	16
282	9	Med	Trauma to the skin subcut tiss and breast age 0–17	.3424	.3424	0	NA	9
283	9	Med	Minor skin disorders with CC	.6365	.7682	20.7	7.3	24
284	9	Med	Minor skin disorders without CC	.5170	.4795	−7.3	5.1	18

285	10	Surg	Amputat of lower limb for endoc., nutrit, and metabol disorders.	3.2719	2.9919	−8.6	23.4	36
286	10	Surg	Adrenal and pituitary procedures	2.6727	2.7063	1.3	14.5	30
287	10	Surg	Skin grafts and wounds debrid for endoc, nutrit, and metab disorders.	2.3776	2.2274	−6.3	19.0	32
288	10	Surg	O.r. procedures for obesity	2.1128	2.0018	−5.3	11.2	26
289	10	Surg	Parathroid procedures	1.3304	1.1470	−13.8	6.9	20
290	10	Surg	thyroid procedures	.8561	.8428	−1.6	4.9	13
291	1	Surg	Thyroglossal procedures	.6072	.4991	−17.8	2.8	8
292	10	Surg	Other endocrine, nutrit and metab O.R. proc with CC	2.3129	2.6027	12.5	17.1	30
293	10	Surg	Other endocrine, nutrit and metab O.R. proc without CC	1.7960	1.1698	−34.9	8.9	24
294	10	Med	Diabetes age greater than 35	.7454	.7493	.5	7.4	21
295	10	Med	Diabetes age 0–35	.7886	.7228	−8.3	5.7	19
296	10	Med	Nutritional and misc metabolic disorders age greater than 17 with CC.	.8271	.9259	11.9	8.0	24
297	10	Med	Nutritional and misc metabolic disorders age greater than 17 without CC.	.6984	.5791	−17.1	5.6	17
298	10	Med	Nutritional and misc metabolic disorders age 0–17	.7203	.7065	−1.9	5.2	20
299	10	Med	Inborn effor of metabolism	.8041	.8271	2.9	6.9	23
300	10	Med	Endocrine Disorders with CC	.9348	1.0862	16.2	9.1	25
301	10	Med	Endocrine disorders without CC	.6882	.6758	−1.8	6.3	22
302	11	Surg	Kidney transplant	4.6267	3.8463	−16.9	19.1	35
303	11	Surg	Kidney, ureter and major bladder procedures for neoplasm	2.7606	2.7747	.5	15.0	31
304	11	Surg	Kidney, ureter and major bladder proc for non-neopl with CC.	2.0322	2.3651	16.4	13.5	28
305	11	Surg	Kidney, ureter and major bladder proc for non-neopl without CC.	1.4893	1.3665	−8.2	8.0	24
306	11	Surg	Prostatectomy with CC	1.2593	1.4376	14.2	10.1	26
307	11	Surg	Prostatectomy without CC	.9585	.9121	−4.8	6.6	17
308	11	Surg	Minor bladder procedures with CC	1.1487	1.5354	33.7	10.2	25
309	11	Surg	Minor bladder procedures without CC	.8644	.8620	−0.3	5.9	22

TABLE 18.—LIST OF DIAGNOSIS RELATED GROUPS (DRG'S), FISCAL YEARS 1987 AND 1988 RELATIVE WEIGHTING FACTORS AND THE PERCENTAGE CHANGE, AVERAGE LENGTH OF STAY, AND OUTLIER THRESHOLD USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

DRG	MDC	Type	Title	Relative weighting factors			Arithmetic mean length of stay	Outlier threshold
				1987	1988	Percent change, 1987–88		
310	11	Surg	Transurethral procedures with CC	.7265	.9026	24.2	6.2	22
311	11	Surg	Transurethral procedures without CC	.5564	.5681	2.1	3.6	11
312	11	Surg	Urethral procedures, age greater than 17 with CC	.7307	.8246	12.9	6.0	21
313	11	Surg	Urethral procedures, age greater than 17 without CC	.5804	.5286	−8.9	3.7	12
314	11	Surg	Urethral procedures, age 0–17	.4323	.4323	0	NA	11
315	11	Surg	Other kidney and urinary tract O.R. procedures	2.7736	2.3635	−14.8	13.0	26
316	11	Med	Renal Failure	1.3210	1.2840	−2.8	9.1	24
317	11	Med	Admit for renal dialysis	.4907	.3542	−27.8	2.4	7
318	11	Med	Kidney and urinary tract neoplasms with CC	.9216	1.0441	13.3	9.1	24
319	11	Med	Kidney and urinary tract neoplasms without CC	.7415	.5777	−22.1	4.9	19
320	11	Med	Kidney and urinary tract infections age greater than with CC.	.8626	1.0230	18.6	8.4	25
321	11	Med	Kidney and urinary tract infections age greater than 17 without CC.	.6750	.7316	8.4	6.5	18
322	11	Med	Kidney and urinary tract infections age 0–17 without CC	.6996	.6829	−2.4	5.0	14
323	11	Med	Urinary stones with CC and/or esw lithotripsy	.5862	.7020	19.8	4.9	16
324	11	Med	Urinary stone without CC	.4096	.5139	25.5	3.1	9
325	11	Med	Kidney and urinary tract signs and symptoms age greater than 17 with CC.	.6503	.6789	4.4	6.0	20
326	11	Med	Kidney and urinary tract signs and symptoms age greater than 17 without CC.	.5156	.4553	−11.7	4.1	13
327	11	Med	Kidney and urinary tract signs and symptoms age 0–17	.5511	.5511	0	NA	21
328	11	Med	Urethral stricture age greater than with CC	.5939	.6266	5.5	5.1	18
329	11	Med	Urethral stricture age greater than 17 without CC	.4870	.4431	−9.0	3.5	12

330	11	Med	Urethral stricture age 0–17	.2788	.2788	0	NA	5
331	11	Med	Other kidney and urinary tract diagnoses age greater than 17 with CC.	.8329	.9050	8.7	7.5	23
332	11	Med	Other kidney and urinary tract diagnoses age greater than 17 with CC.	.6725	.5913	−12.1	5.0	18
333	11	Med	Other kidney and urinary tract diagnoses age 0–17	.7912	.6887	−13.0	4.7	19
334	12	Surg	Major male pelvic procedures with CC	1.8035	1.9237	6.7	12.8	28
335	12	Surg	Major male pelvic procedures without CC	1.4643	1.4080	−3.8	10.0	19
336	12	Surg	Transurethral prostatectomy with CC	.9869	1.0774	9.2	7.7	19
337	12	Surg	Transurethral prostatectomy without CC	.7788	.7505	−3.6	5.4	11
338	12	Surg	Testes procedures for malignancy	.8907	.7865	11.7	5.6	22
339	12	Surg	Testes procedures for non-malignancy age greater than 17	.5766	.5930	2.8	3.8	13
340	12	Surg	Testes procedures for non-malignancy age 0–17	.4335	.4335	0	NA	7
341	12	Surg	Penis procedures	.9970	1.0294	3.2	5.2	15
342	12	Surg	Circumcision age greater than 17	.4265	.4494	5.4	2.8	8
343	12	Surg	Circumcision age 0–17	.3788	.3788	0	NA	4
344	12	Surg	Other male reproductive system O.R. procedures for malignancy.	1.1214	1.1302	.8	7.4	24
345	12	Surg	Other male reproductive system O.R. proc except for malignancy.	.8173	.8284	1.4	5.9	21
346	12	Med	Malignancy, male reproductive system, with CC	.8568	.9360	9.2	8.5	24
347	12	Med	Malignancy, male reproductive system, without CC	.6441	.5091	−21.0	4.0	14
348	12	Med	Benign prostatic hypertrophy with CC	.6257	.6588	5.3	5.4	20
349	12	Med	Benign prostatic hypertrophy without CC	.4853	.4059	−16.4	3.0	9
350	12	Med	Inflammation of the male reproductive system	.6270	.6734	7.4	5.8	16
351	12	Med	Sterilization, male	.3333	.3333	0	NA	5
352	12	Med	Other male reproductive system diagnoses	.5354	.4886	−8.7	3.9	14
353	13	Surg	Pelvic evisceration, radical hysterectomy and radical vulvectomy.	2.3887	2.2997	−3.7	15.2	31
354	13	Surg	Uterine, Adnexa proc for non-ovarian/adnexal malig with CC.	1.3563	1.5482	14.1	10.2	23

TABLE 18.—LIST OF DIAGNOSIS RELATED GROUPS (DRG'S), FISCAL YEARS 1987 AND 1988 RELATIVE WEIGHTING FACTORS AND THE PERCENTAGE CHANGE, AVERAGE LENGTH OF STAY, AND OUTLIER THRESHOLD USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

DRG	MDC	Type	Title	Relative weighting factors			Arithmetic mean length of stay	Outlier threshold
				1987	1988	Percent change, 1987–88		
355	13	Surg	Uterine, adexa proc for non-ovarian/adnexal malig without CC.	1.0359	.9929	−4.2	7.1	13
356	13	Surg	Female reproductive system reconstructive procedures	.8470	.7983	−5.7	6.3	14
357	13	Surg	Uterine and adnexa proc for ovarian or adnexal malig	2.1103	2.1591	2.3	13.2	29
358	13	Surg	Uterine and adnexa proc for non-malignancy with CC	1.1152	1.2941	16.0	9.0	20
359	13	Surg	Uterine and adnexa proc for non-malignancy without CC	.9462	.9025	−4.6	6.6	12
360	13	Surg	Vagina, cervix and vulva procedures	.6338	.6957	9.8	5.2	19
361	13	Surg	Laparoscopy and incisional tubal interruption	.6594	.6442	−2.3	3.9	13
362	13	Surg	Endoscopic tubal interruption	.3510	.4095	16.7	2.0	5
363	13	Surg	D&C, conization and radio-implant for malignancy	.6156	.6597	7.2	4.9	16
364	13	Surg	D&C, conization except for malignancy	.3921	.4262	8.7	2.8	8
365	13	Surg	Other female reproductive system O.R. procedures	1.9085	1.9060	−.1	12.7	28
366	13	Med	Malignancy, female reproductive system with CC	.8624	1.0916	26.6	9.6	24
367	13	Med	Malignancy, female reproductive system without CC	.5353	.5481	2.4	4.9	18
368	13	Med	Infections, female reproductive system	.7610	.8308	9.2	7.2	22
369	13	Med	Menstrual and other female reproductive system disorders	.5496	.4920	−10.5	4.6	17
370	14	Surg	Cesarean section with CC	1.1063	1.0303	−6.9	7.7	19
371	14	Surg	Cesarean section without CC	.7669	.7164	−6.6	5.2	9
372	14	Med	Vaginal delivery with complicating diagnoses	.5942	.4927	−17.1	4.3	12
373	14	Med	Vaginal delivery without complicating diagnoses	.3538	.3212	−9.2	2.7	6
374	14	Surg	Vaginal delivery with sterilization and or D&C	.5754	.5641	−2.0	3.5	7
375	14	Surg	Vaginal delivery with O.R. proc except steril and or D&C	.6817	.6817	0	NA	15
376	14	Med	Postpartum and post abortion diagnoses without O.R. procedure.	.4539	.3520	−22.4	3.3	11

377	14	Surg	Postpartum and post abortion diagnoses with O.R. procedure.	.7698	.9882	28.4	4.7	21
378	14	Med	Ectopic pregnancy	.7357	.7787	5.8	4.4	9
379	14	Med	Threatened abortion	.2409	.2843	18.0	2.8	9
380	14	Med	Abortion without D&C	.3792	.3124	−17.6	2.5	8
381	14	Med	Abortion with D&C, aspiration curettage or hysterotomy	.3725	.3694	−.8	1.9	5
382	14	Med	False labor	.1136	.1309	15.2	1.3	2
383	14	Med	Other antepartum diagnoses with medical complications	.4452	.3964	−11.0	4.6	17
384	14	Med	Other antepartum diagnoses without medical complications.	.4586	.3512	−23.4	3.7	13
385	15		Neonates, died or transferred to another acute care facility.	.6811	1.2232	79.6	8.4	22
386	15		Extreme immaturity or respiratory distress syndrome, neonate.	3.6480	3.6480	0	NA	36
387	15		Prematurity with major problems	1.8267	1.8267	0	NA	31
388	15		Prematurity without major problems	1.1571	1.1571	0	NA	27
389	15		Full-term neonate with major problems	.5425	1.4127	160.4	10.7	25
390	15		Neonate with other significant problems	.3486	.9416	170.1	6.0	20
391	15		Normal newborn	.2218	.2218	0	NA	7
392	16	Surg	Splenectomy age greater than 17	3.2488	3.5252	8.5	16.4	31
393	16	Surg	Splenectomy age 0–17	1.5206	1.5206	0	NA	27
394	16	Surg	Other O.R. procedures of the blood and blood forming organs.	1.0889	1.2250	12.5	7.9	23
395	16	Med	Red blood cell disorders age greater than 17	.7153	.7264	1.6	6.0	22
396	16	Med	Red blood cell disorders age 0–17	.2952	.3441	16.6	2.4	7
397	16	Med	Coagulation disorders	.9969	1.0145	1.8	7.5	23
398	16	Med	Reticuldendothelial and immunity disorders with CC	.9752	1.2115	24.2	8.7	24
399	16	Med	Reticuldendothelial and immunity without CC	.7247	.6830	−5.8	5.6	21
400	17	Surg	Lymphoma and leukemia with major O.R. procedure	3.1139	2.6900	−13.6	15.3	29
401	17	Surg	Lymphoma and non-acute leukemia with other O.R. proc with CC.	1.9327	2.0871	8.0	14.5	28

TABLE 18.—LIST OF DIAGNOSIS RELATED GROUPS (DRG'S), FISCAL YEARS 1987 AND 1988 RELATIVE WEIGHTING FACTORS AND THE PERCENTAGE CHANGE, AVERAGE LENGTH OF STAY, AND OUTLIER THRESHOLD USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

DRG	MDC	Type	Title	Relative weighting factors 1987	1988	Percent change, 1987–88	Arithmetic mean length of stay	Outlier threshold
402	17	Surg	Lymphoma and non-acute leukemia with other O.R. proc without CC.	1.0514	.9252	−12.0	6.6	23
403	17	Med	Lymphoma and non-acute leukemia with CC	1.3493	1.5222	12.8	11.6	26
404	17	Med	Lymphoma and non-acute leukemia without CC	.9101	.8085	−11.2	7.0	23
405	17	Med	Acute leukemia without major O.R. procedure age 0–17	1.0407	1.0407	0	NA	23
406	17	Surg	Myeloprolif disord or poorly diff neopl with maj O.R. proc with CC.	2.5302	2.7146	7.3	16.5	30
407	17	Surg	Myeloprolif disord or poorly diff neopl with maj O.R. proc without CC.	1.7124	1.4499	−15.3	9.5	25
408	17	Surg	Myeloprolif disord or poorly diff neopl with other O.R. proc	1.0500	.8955	−14.7	6.4	22
409	17	Med	Radiotherapy	.9855	1.0802	9.6	10.6	25
410	17	Med	Chemotherapy	.4284	.4742	10.7	3.1	10
411	17	Med	History of malignancy without endoscopy	.5907	.4919	−16.7	3.9	13
412	17	Med	History of malignancy with endoscopy	.3388	.3954	16.7	2.7	8
413	17	Med	Other myeloprolif dis or poorly diff neopl diag with CC	1.0455	1.2385	18.5	10.7	25
414	17	Med	Other myeloprolif dis or poorly diff neopl diag without CC	.8983	.8128	−9.5	7.8	23
415	18	Surg	O.R. procedure for infectious and parasitic diseases	3.3287	3.5067	5.3	19.9	32
416	18	Med	Septecemia age greater than 17	1.6182	1.5894	−1.8	10.4	25
417	18	Med	Septecemia age 0–17	1.1530	.9346	−18.9	6.5	21
418	18	Med	Postoperative and post-traumatic infections	1.0022	.9743	−2.8	8.5	25
419	18	Med	Fever of unknown origin age greater than 17 with CC	.9305	.9778	5.1	7.6	24
420	18	Med	Fever of unknown origin age greater than 17 without CC	.8316	.6949	−16.4	5.8	17
421	18	Med	Viral illness age greater than 17	.5672	.6255	10.3	5.5	16
422	18	Med	Viral illness and fever of unknown origin age 0–17	.6583	.6274	−4.7	5.0	18

423	18	Med	Other infectious and parasitic diseases diagnoses	1.3205	1.5333	16.1	11.2	26
424	19	Surg	O.R. procedure with principal diagnoses of mental illness	2.2113	2.2176	.3	21.6	30
425	19	Med	Acute adjust react and disturbances of psychosocial dysfunction.	.6090	.6004	−1.4	6.0	21
426	19	Med	Depressive neuroses	.8332	.6580	−21.0	8.3	24
427	19	Med	Neuroses except depressive	.7018	.6315	−10.0	8.2	24
428	19	Med	Disorders of personality and impulse control	.8513	.7305	−14.2	9.8	24
429	19	Med	Organic disturbances and mental retardation	.8419	.8868	5.3	10.6	25
430	19	Med	Psychoses	1.0760	.9329	−13.3	13.0	27
431	19	Med	Childhood mental disorders	.6493	.7134	9.9	8.3	24
432	19	Med	Other mental disorder diagnoses	.6968	.7097	1.9	7.0	22
433	20		Alcohol/drug abuse or dependence, left AMA	.3906	.4232	8.3	5.0	20
434	20		ALC/drug abuse or dependence, detox or other sympt TRT with CC.	.7096	.8149	14.8	8.3	24
435	20		ALC/drug abuse or dependence, detox or other sympt TRT without CC.	.7978	.5903	−26.0	7.5	23
436	20		ALC/drug dependence with rehabilitation therapy	1.0166	.9788	−3.7	13.6	27
437	20		ALC/drug dependence, combined rehab and detox therapy	1.3273	1.3306	.2	17.6	32
438	20		No longer valid	.0000	.0000	NA	NA	0
439	21	Surg	Skin grafts for injuries	1.6505	1.7523	6.2	12.9	25
440	21	Surg	Wound debridements for injuries	2.0421	2.2498	10.2	15.6	28
441	21	Surg	Hand procedures for injuries	.7303	.7185	−1.6	3.8	14
442	21	Surg	Other O.R. procedures for injuries with CC	1.8143	1.9218	5.9	9.9	24
443	21	Surg	Other O.R. procedures for injuries without CC	1.4841	1.2169	−18.0	6.9	22
444	21	Med	Multiple trauma age greater than 17 with CC	.7072	.8207	16.0	7.3	23
445	21	Med	Multiple trauma age greater than 17 without CC	.6014	.5183	−13.8	5.0	17
446	21	Med	Multiple trauma age 0–17	.4796	.4796	0	NA	10
447	21	Med	Allergic reactions age greater than 17	.4470	.4703	5.2	3.6	12
448	21	Med	Allergic reactions age 0–17	.3470	.3470	0	NA	9
449	21	Med	Poisoning and toxic effects of drugs age greater than 17 with CC.	.6951	.7922	14.0	6.1	22

TABLE 18.—LIST OF DIAGNOSIS RELATED GROUPS (DRG'S), FISCAL YEARS 1987 AND 1988 RELATIVE WEIGHTING FACTORS AND THE PERCENTAGE CHANGE, AVERAGE LENGTH OF STAY, AND OUTLIER THRESHOLD USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

DRG	MDC	Type	Title	Relative weighting factors			Arithmetic mean length of stay	Outlier threshold
				1987	1988	Percent change, 1987-88		
450	21	Med	Poisoning and toxic effects of drugs age greater than 17 without CC.	.5422	.4917	−9.3	4.1	14
451	21	Med	Poisoning and toxic effects of drugs age 0–17	.5497	.5907	7.5	4.4	14
452	21	Med	Complications of treatment with CC	.8079	.8976	11.1	6.7	23
453	21	Med	Complications of treatment without CC	.7468	.5137	−31.2	4.6	17
454	21	Med	Other injury, poisoning and toxic eff diag with CC	.8099	.9067	12.0	6.8	22
455	21	Med	Other injury, poisoning and toxic eff diag without CC	.6002	.4692	−21.8	4.0	14
456	22		Burns, transferred to another acute care facility	1.8155	1.9811	9.1	10.1	23
457	22		Extensive burns without O.R. procedure	3.2280	2.5317	−21.6	8.5	22
458	22	Surg	Non-extensive burns with skin graft	3.9450	3.7113	−5.9	22.8	34
459	22	Surg	Non-extensive burns with wound debridement or other O.R. proc.	3.2658	1.7964	−45.0	14.6	28
460	22	Med	Non-extensive burns without O.R. procedure	1.1592	1.0495	−9.5	9.2	24
461	23	Surg	O.R. proc with diagnoses or other contact with health services.	1.3548	.7198	−46.9	4.4	17
462	23	Med	Rehabilitation	2.1404	1.7517	−18.2	18.3	32
463	23	Med	Signs and symptoms with CC	.7949	.7633	−4.0	7.0	23
464	23	Med	Signs and symptoms without CC	.6952	.4740	−31.8	4.5	15
465	23	Med	Aftercare with history of malignancy as secondary diagnosis.	.2881	.3172	10.1	2.2	6
466	23	Med	Aftercare without history of malignancy as secondary diagnosis.	.4152	.5383	29.6	5.0	20
467	23	Med	Other factors influencing health status	.7212	.4723	−34.5	6.8	21
468	....		Unrelated operating room procedures	2.4516	2.4679	.7	15.5	28

469	....		Principal diagnosis invalid as discharge diagnosis	.0000	.0000	NA	NA	0
470	....		Ungroupable	.0000	.0000	NA	NA	0
471	8	Surg	Bilateral or multiple major joint procs of lower extremity	3.6991	4.0896	10.6	20.7	36
472	22	Surg	Extensive burns with O.R. procedure	12.3234	10.7296	−12.9	29.6	35
473	17	Med	Acute leukemia without O.R. procedure age greater than 17.	2.3275	2.7107	16.5	14.8	26
474	4		Tracheostomy	NA	11.8772	NA	42.9	51
475	4	Med	Mechanical ventilation through endotrachial intubation	NA	3.1757	NA	12.8	27

NA—Not applicable.

Source: ProPAC and Federal Register, Vol. 52, No. 169, Sept. 1, 1987.

TABLE 19.—DISTRIBUTION OF PERCENT CHANGE IN DRG WEIGHTS

Percent change in DRG weight	Fiscal year 1986 recalibration		Fiscal year 1988 recalibration	
	Percent of DRGs	Percent of cases	Percent of DRGs	Percent of cases
< −20	9.6	4.2	4.7	1.4
−10.1 to −20	14.8	9.9	12.4	7.0
−5.1 to −10	14.1	19.8	14.1	15.0
−0.1 to −5	14.8	29.8	14.3	17.2
0	7.7	<.01	6.8	<.01
0.1 to 5	11.3	9.6	14.1	25.5
5.1 to 10	9.0	14.3	12.2	11.6
10.1 to 20	9.8	9.4	13.0	17.9
20+	9.8	2.7	7.9	4.1

Source: ProPAC analysis of MEDPAR data from fiscal years 1984 and 1986.

TABLE 20.—PROPORTION OF HOSPITALS, DISCHARGES AND PPS PAYMENTS, BY HOSPITAL TYPE

[In Percent] [1]

Hospital type	Hospitals	Discharges	PPS payments [2]
All hospitals	100	100	100
Urban	51	75	84
Rural referral centers	3	4	4
Other rural	46	21	12
Major teaching	3	7	12
Other teaching	16	32	37
Nonteaching	81	61	51
Disproportionate share	22	28	33
Nondisproportionate share	78	72	67
New England	5	6	6
Middle Atlantic	9	14	17
South Atlantic	14	16	14
East North Central	16	19	20
East South Central	9	9	7
West North Central	13	9	8
West South Central	15	11	10
Mountain	7	4	4
Pacific	13	12	14
Urban <100 beds	11	4	4
Urban 100 to 249 beds	19	19	19
Urban 250 to 404 beds	12	23	25
Urban 405 to 684 beds	7	21	25

TABLE 20.—PROPORTION OF HOSPITALS, DISCHARGES AND PPS PAYMENTS, BY HOSPITAL TYPE—Continued

[In Percent] [1]

Hospital type	Hospitals	Discharges	PPS payments [2]
Urban 685 + beds	2	9	12
Rural <50 beds	21	4	2
Rural 50 to 99 beds	16	7	4
Rural 100 to 169 beds	8	7	4
Rural 170 + beds	4	7	5

[1] Columns may not sum to total due to rounding.

[2] PPS payments computed under fiscal year 1987 rules as if all hospitals had accounting years identical to the Federal fiscal year.

Source: ProPAC estimates bases on fiscal year 1985 MEDPAR patient billing data and hospital-level data from the U.S. Department of Health and Human Services, Health Care Financing Administration.

TABLE 21.—DISTRIBUTION OF PAYMENTS UNDER FULLY NATIONAL PPS RATES, BY TYPE OF PAYMENT

[In Percent]

Hospital type	Basic payment	Outlier payment [1]	Indirect teaching payment [2]	Disproportionate share payment [3]
All hospitals	90.0	4.2	4.1	1.7
Urban	88.4	4.7	4.9	2.0
Rural referral centers	95.3	2.8	1.9	([4])
Other rural	97.7	1.8	.2	.2
Major teaching	67.9	7.6	20.3	4.2
Other teaching	87.6	4.9	5.8	1.7
Nonteaching	95.7	3.2	0	1.1
Disproportionate share	81.8	5.5	7.3	5.5
Nondisproportionate share	93.5	3.7	2.8	0
New England	83.3	9.5	6.5	.8
Middle Atlantic [5]	87.5	4.5	6.6	1.4
South Atlantic	89.9	4.8	3.4	1.9
East North Central	89.1	4.1	5.3	1.5
East South Central	92.1	3.6	2.1	2.3
West North Central	92.4	3.2	3.6	.9
West South Central	92.8	2.9	2.4	1.9
Mountain	93.3	2.8	3.1	.7
Pacific	90.1	3.7	3.7	2.6
Urban > 100 beds	96.7	2.6	.5	.3
Urban 100–249 beds	92.4	3.8	1.5	2.3
Urban 250–404 beds	90.0	4.6	3.5	1.9

TABLE 21.—DISTRIBUTION OF PAYMENTS UNDER FULLY NATIONAL PPS RATES, BY TYPE OF PAYMENT—Continued

[In Percent]

Hospital type	Basic payment	Outlier payment [1]	Indirect teaching payment [2]	Disproportionate share payment [3]
Urban 405–684 beds	85.8	5.3	7.0	1.9
Urban 685+ beds	80.4	6.1	11.2	2.2
Rural > 50 beds	98.5	1.1	([4])	.4
Rural 50–99 beds	98.2	1.4	.1	.3
Rural 100–169 beds	97.7	1.9	.3	.1
Rural 170+ beds	95.2	3.1	1.6	.1

Rows may not add to 100 percent due to rounding.

[1] Includes indirect teaching and disproportionate share payments earned on outlier cases.

[2] Excludes indirect teaching payments earned on outlier cases.

[3] Excludes disproportionate share payments earned on outlier cases.

[4] Less than 0.1 percent.

[5] New York hospitals were excluded from estimates presented in this table. Estimated payments to New York may be overstated. In particular, predicted outlier payments are unlikely to be entirely realized because PPS has incentives to reduce length of stay.

Source: ProPAC estimates based on fiscal year 1985 MEDPAR patient billing data and hospital-level data from the U.S. Department of Health and Human Services, Health Care Financing Administration.

TABLE 22.—DISTRIBUTION OF ESTIMATED PAYMENTS FOR PROSPECTIVE PAYMENT SYSTEM USING COBRA ASSUMPTIONS

Payment type	With New York and Massachusetts		Without New York and Massachusetts	
	Payment amount (in millions)	Percent of total payments	Payment amount (in millions)	Percent of total payments
Regular payment amount	$35,781	92.21	$31,894	93.13
Day outlier payments	1,092	2.81	747	2.18
Cost outlier payments	159	.41	153	.45
Indirect teaching payments	1,061	2.73	822	2.40
Disproportionate share payments	422	1.09	339	.99
Transfer payments	290	.75	290	.85
Total	38,804	100.0	34,246	100.00
Outlier payments as a percent of total		3.22		2.63
Outlier payments as a percent of regular payments		3.38		2.75
Outlier payments as a percent of Federal portion & outlier payments		6.29		5.14

Note: Estimated payment amounts based on patient bills in FY 1984 for 5,635 hospitals. All 1984 charge information is inflated to 1986 based upon Social Security II–B assumptions. All estimates assume that COBRA changes to PPS are in effect for the full Federal fiscal year.

Source: U.S. Library of Congress. Congressional Research Service.

TABLE 23.—SUMMARY CHARACTERSTICS OF HOSPITALS [1]

Type of hospital	Number of hospitals	Discharges per hospital	Percent of all discharges	Average bedsize	Average case mix index	Average wage index	Average regular payment per case
All hospitals	5,635	1,810	100.0	144	1.059	0.982	$3,508.69
Urban hospitals	2,874	2,661	75.0	215	1.113	1.092	3,913.31
Rural hospitals	2,761	923	25.0	70	1.002	.868	2,294.85
		Urban Hospitals					
Regions (9 census)	2,874	2,661	75.0	215	1.113	1.092	$3,913.31
East North Central	532	2,768	14.4	250	1.121	1.102	4,175.18
East South Central	171	2,832	4.7	197	1.068	.932	3,211.17
Middle Atlantic	383	3,269	12.3	239	1.087	1.143	3,902.05
Mountain	112	2,446	2.7	213	1.145	1.094	3,968.34
New England	185	2,796	5.1	205	1.040	1.074	3,738.65
Pacific	526	2,075	10.7	154	1.156	1.281	4,590.70
South Atlantic	407	3,017	12.0	233	1.116	.966	3,561.56
West North Central	194	2,749	5.2	248	1.132	1.066	3,926.24
West South Central	364	2,187	7.8	207	1.102	.989	3,573.46
Bedsize	2,874	2,661	75.0	215	1.113	1.092	3,913.31
Urban hospitals with < 100 beds	666	712	4.6	58	1.013	1.078	3,153.03
Urban hospitals with 100–404 beds	1,652	2,570	41.6	209	1.124	1.095	3,741.85
Urban hospitals with 405 + beds	500	5,772	28.3	470	1.224	1.098	4,289.29
Teaching status	2,874	2,661	75.0	215	1.113	1.092	3,913.31
Nonteaching hospitals	1,910	2,049	38.4	162	1.081	1.078	3,568.93
Minor teaching hospitals	789	3,882	30.0	312	1.167	1.109	4,095.83
Major teaching hospitals	175	3,841	6.6	365	1.219	1.169	5,086.26
Urban hospitals	2,874	2,661	75.0	215	1.113	1.092	3,913.31
Other	1,405	1,988	27.4	152	1.079	1.081	3,577.62
Disproportionate share hospitals	505	2,216	11.0	188	1.088	1.069	3,547.23

TABLE 23.—SUMMARY CHARACTERSTICS OF HOSPITALS [1]—Continued

Type of hospital	Number of hospitals	Discharges per hospital	Percent of all discharges	Average bedsize	Average case mix index	Average wage index	Average regular payment per case
Teaching only	519	4,265	21.7	320	1.178	1.112	4,175.04
Disproportionate share and teaching	445	3,420	14.9	323	1.176	1.129	4,418.05
		Rural hospitals					
Regions (9 census)	2,761	923	25.0	70	1.002	.868	2,294.85
East North Central	376	1,095	4.0	88	1.022	.922	2,493.37
East South Central	328	1,129	3.6	83	.9670	.768	1,990.77
Middle Atlantic	105	1,726	1.8	124	1.015	.903	2,634.18
Mountain	282	488	1.3	39	.9962	.931	2,468.07
New England	62	1,192	.7	62	1.049	.902	2,827.02
Pacific	175	677	1.2	50	1.054	1.118	2,932.95
South Atlantic	356	1,290	4.5	92	1.016	.813	2,250.03
West North Central	612	676	4.1	56	1.001	.850	2,185.04
West South Central	465	826	3.8	60	.9780	.816	2,025.55
Bedsize	2,761	923	25.0	70	1.002	.868	2,294.85
Rural hospitals with < 100 beds	2,177	598	12.8	43	.9853	.870	2,151.47
Rural hospitals with 100–404 beds	577	2,088	11.8	163	1.064	.860	2,429.70
Rural hospitals with 405 + beds	7	6,195	.4	529	1.209	.830	2,851.95
Teaching status	2,761	923	25.0	70	1.002	.868	2,294.85
Nonteaching hospitals	2,689	879	23.2	66	1.000	.868	2,257.70
Minor teaching hospitals	64	2,524	1.6	192	1.077	.878	2,678.92
Major teaching hospitals	8	2,991	.2	209	1.163	.895	3,371.76

Rural hospitals	2,761	923	25.0	70	1.002	.868	2,294.85
Other rural hospitals	2,297	840	18.9	64	.9942	.857	2,200.23
Regional referral centers	140	2,973	4.1	208	1.130	.865	2,616.16
Sole community providers	324	627	2.0	49	1.005	.944	2,535.65

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[1] Estimates based on fiscal year 1986 payment policies, after May 1, 1986, applied to data for fiscal year 1984 supplied by the Health Care Financing Administration.

Source: U.S. Library of Congress, Congressional Research Service.

APPENDIX E. MEDICARE REIMBURSEMENT TO PHYSICIANS

Reasonable Charges

Medicare pays for physicians' services on the basis of "*reasonable charges.*" Recently, HCFA has begun calling these charges "*approved charges.*" A reasonable or approved charge for a service (in the absence of unusual circumstances) cannot exceed:

—the *actual charge* for the service;

—the physician's *customary charge* for the service; and

—the *prevailing charge* for similar services in the locality (set at a level no higher than is necessary to cover the 75th percentile of customary charges).

Carriers delineate localities which are usually political or economic subdivisions of a State. There are 225 localities nationwide.

Prior to 1984, customary and prevailing charge fee screens were updated every July 1. The annual update in the prevailing charge screens was subject to an *economic index limitation.* This limitation (expressed as a maximum allowable percentage increase) is tied to economic indexes reflecting changes in operating expenses of physicians and in earnings' levels (see table 1).

Because the Deficit Reduction Act of 1984 (DEFRA) froze physicians' fees through September 30, 1985, the annual increases in the customary and prevailing charge screens otherwise slated for July 1, 1984, did not occur. Subsequent fee screen updates were slated to occur on October 1 of future years beginning in 1985. However, the increase slated to occur on October 1, 1985, was postponed. The next update occurred on May 1, 1986, for participating physicians only (see discussion of participating physicians, below).

The customary and prevailing charges of all physicians were updated on January 1, 1987. Increases in the prevailing charge screens were limited by a congressionally determined 3.2 percent increase in the MEI. In 1987, and in future years, the MEI applies separately to the prevailing charges of participating and nonparticipating physicians, providing for a permanent differential in prevailing charges based on participation status.

The Omnibus Budget Reconciliation Act of 1987 (OBRA87) delayed the customary and prevailing charge screen update scheduled to occur on January 1, 1988, until April 1, 1988. OBRA87 allows for greater increases in the prevailing charges for primary care services (office, home, emergency room, and nursing home visits) than for other services, and increases the differential between participating and nonparticipating physicians. For the 9-month period beginning April 1, 1988, participating physicians will receive an MEI increase of 3.6 percent for primary care services and 1.0 percent for other services. Nonparticipating physicians will receive an MEI increase of 3.1 percent for primary care services and 0.5 percent for other services. On January 1, 1989, the MEI for primary care and other services will increase by 3.0 and 1.0 percent respectively for participating physicians and by 2.5 and 0.5 percent for nonparticipating physicians. OBRA87 also provides for incentive payments equal to 5 percent of allowed charges for primary care services furnished by all physicians in certain rural health manpower shortage areas after January 1, 1989, and in certain urban and rural health manpower shortage areas after January 1, 1990.

Medicare payments for services provided on or after November 21, 1987, are subject to a 2.3 percent reduction under the final sequestration order issued under the Gramm-Rudman-Hollings Act, as amended. OBRA87 provides that these reductions in payments are to remain in effect for services rendered through March 31, 1988.

TABLE 1.—ECONOMIC INDEX VALUES AND PERCENTAGE INCREASE OVER PRIOR PERIOD

Period	Rates	Percent [1]
July 1, 1973	1.000	
July 1, 1975 to June 30, 1976	1.179	[2] 17.90
July 1, 1976 to June 30, 1977	1.276	8.23
July 1, 1977 to June 30, 1978	1.357	6.35
July 1, 1978 to June 30, 1979	1.426	5.08
July 1, 1979 to June 30, 1980	1.533	7.50
July 1, 1980 to June 30, 1981	1.658	8.15
July 1, 1981 to June 30, 1982	1.790	7.96
July 1, 1982 to June 30, 1983	1.949	8.88
July 1, 1983 to June 30, 1984	2.063	5.85
July 1, 1984 to Sept. 30, 1985	[3] 2.132	[3] 3.34
Oct. 1, 1985 to Sept. 30, 1986	[3] 2.128	[3] 3.15
May 1, 1986 to Dec. 31, 1986	[4] 2.149	[4] 4.15
Jan. 1, 1987 to Mar. 31, 1987	2.218	3.20
Apr. 1, 1988 to Dec. 31, 1988	[5] 2.298	[5] 3.60

[1] Percent increase over prior period.

[2] Large increase due to delay in implementation.

[3] Not applicable due to fee freeze.

[4] Updated the prevailing charge for participating physicians only.

[5] Update for primary care services of participating physicians.

DEFINITION OF "ASSIGNMENT"

Medicare payments are made either directly to the doctor or to the patient depending upon whether the physician has accepted assignment for the claim. In the case of *assigned claims,* the beneficiary assigns (i.e., transfers) his right to payment from Medicare to the physician. In return, the physician agrees to accept Medicare's "reasonable" charge determination as payment in full for covered services. The physician bills the program directly and is paid an amount equal to 80 percent of Medicare's reasonable charge (less any deductible, where applicable). The patient is liable for the 20 percent coinsurance. The physician may not charge the beneficiary (nor collect from another party such as a private insurer) more than the applicable deductible and coinsurance amounts. When a physician accepts assignment, the beneficiary is therefore protected against having to pay any difference between Medicare's approved charge and the physician's actual charge. In fiscal year 1986 approximately 68 percent of net claims were paid on an assignment basis. In the case of *nonassigned claims,* payment is made by Medicare directly to the beneficiary on the basis of any itemized bill, paid or unpaid. The beneficiary is responsible for paying the physician's bill. In addition to the deductible and coinsurance amounts, the beneficiary is liable for any difference between the physician's actual charge and Medicare's approved charge.

A physician (except one who becomes a participating physician) may accept or refuse requests for assignment on a bill-by-bill basis, from different patients at different times, or from the same patient at different times. However, he is precluded from fragmenting bills for the purpose of circumventing reasonable charge limitations. He must either accept assignment or bill the patient for all of the services performed on a single occasion. Additionally, when a physician treats a patient who is also eligible for Medicaid, he is essentially required to accept assignment. Total reimbursement for services provided to these dual eligibles is equivalent to the Medicare-determined approved charge with Medicaid reimbursing for the required deductible and coinsurance amounts.

Claims for diagnostic laboratory tests, whether performed by physicians, independent laboratories or hospital outpatient laboratories, may only be reimbursed on an assigned basis. OBRA87 authorizes the Secretary to impose civil money penalties or to exclude from Medicare for up to 5 years persons who repeatedly bill beneficiaries for these tests on an unassigned basis.

The law specifies that a physician who knowingly, willfully, and repeatedly violates his assignment agreement is guilty of a misdemeanor. The penalty for conviction is a maximum $2,000 fine, up to 6 months' imprisonment, or both.

PARTICIPATING AND NONPARTICIPATING PHYSICIANS

A physician may become a *participating physician.* A participating physician is one who voluntarily enters into an agreement with the Secretary to accept assignment for all services provided to all Medicare patients for a future specified period, generally 12 months. The first such period began October 1, 1984. Beginning January 1, 1987, the participation periods are on a calendar year basis. However, for the first three months of 1988, participation agreements entered into for 1987 are presumed to continue in effect unless the physician requests to have the agreement terminated. A special 9 month participation period will begin on April 1, 1988, after which participation periods will again begin on January 1 of each subsequent year. The law requires physicians to sign up prior to the start of the participation period. After that time, only new physicians in an area or newly licensed physicians may enter into a participation agreement until the beginning of the next designated time period. A physician who has signed up for one participation period is deemed to have signed up for future periods unless he terminates his agreement.

A *nonparticipating physician* is a physician who has not signed a voluntary participation agreement. A nonparticipating physician may accept assignment on a case-by-case basis.

The law includes a number of incentives to encourage physicians to become participating physicians. During the freeze period the primary incentive for physicians to participate was the ability to increase their billed charges. While increases in billed charges did not raise Medicare payments during the freeze period, these charges will be reflected in the calculation of future customary charge screen updates. The freeze was lifted for participating physicians on May 1, 1986; these physicians received an increase of 4.15 percent in their maximum allowable prevailing charges. Nonparticipating physicians were subject to the freeze through December 31, 1986. During the entire freeze period, nonparticipating physicians could not raise their actual charges above the levels charged during April–June 1984. Thus, there are two prevailing charge levels applicable for physicians in a locality—one for participating physicians and one for nonparticipating physicians that is 4 percent lower. Due to differential updates in the MEI in 1988 and 1989, the difference between prevailing charges for participating and nonparticipating physicians will increase to 5 percent by 1989.

The freeze was lifted for nonparticipating physicians effective January 1, 1987. However, these physicians are subject to a limit on their actual charges. (This is referred to as the maximum allowable actual charge or MAAC). Nonparticipating physicians whose actual charge for a service in the preceding year equals or exceeds 115 percent of the current year's prevailing charge could increase their actual charges by 1 percent. Nonparticipating physicians whose actual charge for the preceding year is below 115 percent of the current year's prevailing charge would be subject to a less restrictive limit; they could increase their actual charges over a 4-year period so that in the fourth year the actual charge equals 115 percent of the prevailing charge. The MAAC for a nonparticipating physician whose actual charge for a service in the previous year is less than 115 percent of the current year's prevailing charge is the greater of: (i) the amount which is 1 percent above the physician's previous year's actual charge; or (ii) an amount based on a comparison between the physician's MAAC for the previous year and 115 percent of the current prevailing charge. Under clause (ii), the MAAC for the current year equals the previous year MAAC increased by a fraction of the difference between 115 percent of the current year prevailing and the previous year MAAC. The applicable fractions are one-quarter, one-third, one-half and one for 1987, 1988, 1989, and 1990, respectively. For example, if a physician's 1986 MAAC for a service is $100 and 115 percent of the 1987 prevailing charge amount is $124, the 1987 MAAC for that physician for that service is $106 [$100 + 0.25 ($124 − $100)].

In addition to the payment provisions, the law includes additional incentives to become participating physicians. These include the publication of directories identifying participating physicians, and the maintenance by carriers of toll-free telephone lines to provide beneficiaries with names of participating physicians. Further, beginning on October 1, 1986, all "Explanation of Medicare Benefits"

(EOMB) notices sent to Medicare beneficiaries on unassigned claims must include a reminder of the participating physician and supplier program.

The law requires the Secretary to monitor charges of nonparticipating physicians to determine compliance with the fee freeze and the MAAC limits.

Nonparticipating physicians who are in violation of the freeze or the MAAC limits could be subject to civil monetary penalties or assessments, exclusion for up to 5 years from the Medicare program, or both. Civil monetary penalties may be imposed in amounts up to $2,000 for each violation. The Secretary is given authority to make restitution to the beneficiary out of the amounts collected for any excess payments made by the beneficiary.

The Secretary may not impose the exclusion penalty in the case of a doctor who is the sole physician serving a community or a physician providing essential specialized services that would otherwise be unavailable. Further, the Secretary, in determining whether to bar a physician from the program, is required to take into account the access of beneficiaries to physicians' services.

"INHERENT REASONABLENESS" GUIDELINES

By law, the Secretary is authorized to establish a payment limit for a physicians' service based on considerations other than actual, customary, or prevailing charges for the service. A departure from the standard is appropriate under a number of specified circumstances, including the following:

—Prevailing charges in a locality are significantly in excess of or below prevailing charges in other comparable localities, taking into account the relative costs of furnishing services.

—Medicare and Medicaid are the sole or the primary sources for payment.

—The marketplace is not truly competitive.

—There have been increases in charges for a service that cannot be explained by inflation or technology.

—The charges do not reflect changing technology, increased facility with that technology, or changes in acquisition or production costs.

—The prevailing charges for a service are substantially higher or lower than payments by other purchasers in the same locality.

The Secretary is authorized to make an adjustment in payment if it is justified on the basis of an appropriate comparison of resource costs or charges. An adjustment may be based on one of the following types of comparisons: charges and resource costs for related procedures, charges and resource costs for a procedure over a period of time, charges for a procedure in different geographic areas, and Medicare charges and allowed payments for a procedure compared to those of other payors.

An adjustment in prevailing charges may be made only if the Secretary determines that a prevailing charge allowed in a locality is out of line with prevailing charges allowed in other localities after accounting for differences in practice costs.

In determining whether to adjust payment rates, the Secretary would be required to consider the potential impacts on quality, access, and beneficiary liability including the likely effects on assignment rates, reasonable charge reductions on unassigned claims, and participation rates of physicians.

The law specifies procedures the Secretary is required to follow in the case of proposed modification in payments based on inherent reasonableness criteria. If an adjustment is made which results in a reduction in allowed payments, a special limit on actual charges for nonparticipating physicians would apply. For the first year the reduction is in effect, the maximum allowable actual charge for the service equals 125 percent of the inherently reasonable charge level plus one-half of the difference between the physician's actual charge in the preceding period and 125 percent of the inherently reasonable charge. In the second year, the maximum allowable charge for the service equals 125 percent of the inherently reasonable charge level.

REDUCTIONS IN PAYMENTS FOR CATARACT SURGERY AND OTHER SERVICES

Cataract surgery involves the removal (by various means) of the natural lens of the eye and replacement of the lens by a prosthetic (artificial) lens. Under the provisions of Public Law 99-509, the maximum allowable prevailing charges, otherwise recognized for participating and nonparticipating physicians performing a cataract surgical procedure, are to be reduced by 10 percent with respect to procedures performed in 1987. In no case may the reduction for a surgical procedure result in a prevailing charge that is less than 75 percent of the weighted national average of such prevailing charges for such procedure for all localities in the United States in 1986. Public Law 99-509 also placed a limit on payments for anesthesia services furnished by physicians during cataract surgery.

OBRA87 imposed additional reductions in payments for cataract surgery and on other physician services including: bronchoscopy, carpal tunnel repair, coronary artery bypass surgery, diagnostic and/or therapeutic dilation and curettage, knee arthroscopy, knee arthroplasty, pacemaker implantation, total hip replacement, suprapubic prostatectomy, transurethral resection of the prostate, and upper gastrointestinal endoscopy. The reduction in prevailing charges for these services rendered after April 1, 1988, is equal to 2 percent plus an additional amount (up to a maximum of 15 percent) depending on the amount by which the prevailing charge in a locality exceeds 85 percent of the national average prevailing charge in 1987. The prevailing charges for these procedures may not be reduced such that the prevailing charge in 1988 is less than 85 percent of the national average prevailing charge in 1987. OBRA87 also imposes a special limit on the actual charges for these services by nonparticipating physicians identical to the limits that would apply under an inherent reasonableness adjustment.

RECENT LEGISLATION

Recent legislation, beginning with the enactment of DEFRA in 1984, made significant modifications in the physician payment provisions of Medicare.

DEFRA froze physicians' fees under Medicare for the 15-month period, July 1, 1984, through September 30, 1985. Therefore, the annual updating of customary and prevailing charge screens, otherwise slated for July 1, 1984, did not occur. Subsequent fee screen updates were slated to occur on October 1 of future years beginning in 1985. DEFRA established the concept of participating physicians and specified that the first participation period began October 1, 1984. Participating physicians were subject to the 15-month freeze. They were, however, permitted to increase their billed charges during the freeze period. The law included additional incentives for physicians who agreed to become participating physicians. These included the publication of directories identifying participating physicians and the maintenance by carriers of toll free lines to provide beneficiaries with names of participating physicians.

The law specified that nonparticipating physicians could not increase their billed charges during the 15-month freeze period over the amounts charged for the same services during the April 1, 1984, through June 30, 1984, period. DEFRA required the Secretary to monitor charges of nonparticipating physicians and specified penalties for those who failed to comply with the freeze.

The Temporary Emergency Extension Act of 1985 (P.L. 99-107), as amended, extended the fee freeze provisions through March 14, 1986.

COBRA extended the existing payment provisions through April 1986. In April 1986, physicians were given an opportunity to change their participation status for the 8-month period beginning May 1, 1986. Future update and participation cycles begin on January 1 of each year beginning in 1987. Physicians covered under participation agreements on May 1, 1986, received updates in their customary and prevailing charges. The freeze was extended through December 31, 1986, for nonparticipating physicians. COBRA provided that, beginning January 1, 1987, nonparticipating physicians would be subject to the prevailing charge limits applied to participating physicians during the preceding participation period. (See modification contained in Public Law 99-509, discussed below.)

COBRA also provided for the establishment of an independent Physician Payment Review Commission. The mission and ongoing duties are to make recommendations regarding Medicare physician payments. The Commission members were appointed on June 11, 1986.

The Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509) made a number of changes in the physician payment provisions, as follows:

—Beginning in 1987, all participating and all nonparticipating physicians will receive an increase in their prevailing charge levels, above those in effect for the previous period equal to 3.2 percent.

—The 1 percentage point increase over the MEI, which was allowed for participating physicians for the period beginning May 1, 1986, was built into the base for future calculations.

—The Secretary cannot retrospectively revise the calculation of the MEI. The Secretary is required to conduct a study of the

MEI to ensure that the index reflects economic changes in an appropriate and equitable manner.

—Nonparticipating physicians are subject to a limit on their actual charges.

—Where the actual charge for a nonassigned elective surgical procedure exceeds $500, the physician is required to disclose to the individual in writing, the estimated charge, the estimated approved charge, the excess of the physician's actual charge over the approved charge, and the applicable coinsurance amount.

Public Law 99-509 authorizes the Secretary under the inherent reasonableness authority, to establish a payment level for physician services based on criteria other than the actual, customary, and prevailing charge for the service. The law specifies criteria and procedures for adjusting payment levels. The Secretary is required to review, by October 1, 1987, the inherent reasonableness of payments for 10 of the most costly procedures paid for under Part B. The law also provided for reductions in prevailing charges for cataract surgical procedures.

Public Law 99-509 requires the Secretary to study and report to Congress by July 31, 1987, concerning the design and implementation of a prospective payment system for payment under Part B for radiology, anesthesiology, and pathology services (RAP services) furnished to hospital inpatients.

COBRA required the Secretary, with the advice of the newly established Physician Payment Commission, to develop a relative value scale (RVS) for physician payments. Public Law 99-509 defers the date the Secretary is required to report on the RVS to July 1, 1989. The potential application date of the RVS is deferred until after December 31, 1989.

The Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) provides for a number of changes in physician payments. These are as follows:

—The MEI is set to permit faster growth in the prevailing charges of primary care services and for services provided by participating physicians. The differential in prevailing charges between participating and nonparticipating physicians will increase to 5 percent in 1989. The MEI updates in 1988 for primary care services are 3.6 and 3.1 percent for participating and nonparticipating physicians respectively. For other services, the updates are 1.0 and 0.5 percent for participating and nonparticipating physicians. The MEI update in 1988 is delayed from January 1 until April 1.

—The 2.3 percent reduction in payments under Medicare required by the final sequestration order issued under the provisions of the Gramm-Rudman-Hollings Act (as amended) remains in effect through March 31, 1988.

—The prevailing charges of 12 procedures, including cataract and coronary artery bypass surgery, are reduced by 2 percent plus an additional amount up to 15 percent based on a sliding scale; that is, localities with high charges relative to the national average are reduced by a greater amount than areas with low charges.

—The Secretary is required to develop relative value scales (RVS) for radiology, anesthesiology, and pathology services. Certain radiology services provided after January 1, 1989 (services performed by board certified or board-eligible radiologists or by physicians for whom radiology services represent at least 50 percent of their Medicare charges), are to be reimbursed on the basis of an RVS-based fee schedule, set at 97 percent of "budget neutral" fee schedule amounts. Anesthesiology services provided after January 1, 1989, are to be reimbursed based on a nationally defined RVS.

Public Law 100–203 prohibits physicians from billing in excess of the acquisition cost for diagnostic services (other than laboratory tests) that are not performed or supervised by the physician. Physicians are also prohibited from billing patients for laboratory tests that are only covered under Medicare when billed on an assigned basis.

Public Law 100–203 provides for reductions in Medicare payments to physicians to collect past-due obligations arising out of scholarships under the National Health Services Corps Scholarship Program.

The Secretary is required to conduct a variety of studies relating to physician reimbursement and to prepare for the potential implementation of a new reimbursement system based on an RVS. These studies include the development of uniform definitions of physician services, expansion of the on-going cost-based RVS study to include additional services, and a study of technical issues related to implementation of an RVS-based fee schedule for physician services. The Secretary is also required to study issues related to the volume and intensity of services provided under Part B and to study beneficiary liability for Medicare services, including liability for excess charges on unassigned claims.

ASSIGNMENT RATE EXPERIENCE

The total number of assigned claims as a percentage of total claims received by medicare carriers is known as the total assignment rate. The net assignment rate was computed in the same manner except that it omitted hospital-based physicians and group-practice prepayment plans which were considered assigned by definition (this distinction is no longer made). The net assignment rate declined since 1968, the year the Department of Health, Education, and Welfare (now the Department of Health and Human Services) began reporting this data. In the mid-1970's the rate leveled off at about 50 percent. Recently the rate has increased significantly. This reflects both the impact of the participating physician program as well as the new requirement that laboratory services must be paid on an assigned basis. Table 2 shows the net assignment rates for calendar years 1968–86 and for fiscal year 1987.

TABLE 2.—NET ASSIGNMENT RATES, BY YEAR, 1968–87

[In percent]

Calendar year	Net assignment rate [1]
1968	59.0
1969	61.5
1970	60.8
1971	58.5
1972	54.9
1973	52.7
1974	51.9
1975	51.8
1976	50.5
1977	50.5
1978	50.6
1979	51.3
1980	51.5
1981	52.3
1982	53.0
1983	53.9
1984	59.0
1985	68.5
1986	68.0
1987 [2]	71.7

[1] Represents the number of assigned claims as a percent of claims received, excluding claims from hospital-based physicians and group-practice prepayment plans that are considered assigned by definition.

[2] Fiscal year 1987.

Source: U.S. Department of Health and Human Services.

The statistics included in table 2 are program-wide data. Assignment rates also vary geographically. For example, the assignment rate (taken as a percent of dollars) in 1987 ranged from a low of 36.5 percent in Idaho to a high of 95.7 percent in Massachusetts. The national average during this period was nearly 72 percent (see table 4).

TABLE 3.—NET ASSIGNMENT RATES, BY REGION, 1969, 1980, 1985, 1986, AND 1987

[In percent]

Region	1969 [1]	1980 [2]	1985 [3]	1986 [3]	1987 [3]
Boston	73.7	67.4	80.5	81.6	85.2
New York	48.7	51.8	70.5	71.5	73.4
Philadelphia	57.3	61.6	81.0	82.0	84.0
Atlanta	58.8	52.3	65.2	64.8	70.3
Chicago	54.5	47.6	65.0	65.1	68.7
Dallas	71.1	50.3	62.3	62.4	67.6
Kansas City	63.8	40.2	56.9	57.1	62.9
Denver	73.0	39.5	52.5	51.4	56.0
San Francisco	70.5	53.2	70.4	70.4	73.7
Seattle	64.8	31.3	45.7	46.0	51.7

[1] Department of Health, Education, and Welfare, Social Security Administration, Office of Research and Statistics. DHEW pub. No. (SSA) 72-11702, HI-33, Jan. 10, 1972. p. 6.

[2] Department of Health and Human Services, Health Care Financing Administration, Bureau of Program Operations, Analysis of Medicare Part B Assignment Rates: Calendar year 1981, n.d.

[3] Health Care Financing Administration.

TABLE 4.—NET ASSIGNMENT RATES OF PART B CARRIERS, CALENDAR YEAR 1980 AND FISCAL YEARS 1985, 1986, AND 1987

Carrier	1980	1985	1986	1987
Total	51.5	67.7	68.0	71.1
Boston region	67.4	80.5	81.6	85.2
Connecticut—General*	44.1	65.3	64.3	*69.7
Maine-Massachusetts B/S [1]	67.8	76.3	[4] 75.3	[4] 79.4
Massachusetts B/S	77.9	89.8	92.6	95.7
New Hampshire-Vermont B/S	51.1			
New Hampshire	48.3	58.9	[4] 56.7	[4] 59.5
Vermont	56.2	64.0	[4] 63.3	[4] 69.4
Rhode Island	81.6	91.1	92.0	92.8
New York region	51.8	70.5	71.5	73.4
New Jersey—Prudential	48.6	66.3	65.2	65.0
New York B/S—Binghamton	56.7	73.1	73.3	75.9
New York B/S—New York	53.8	72.0	73.2	75.0
New York—Group Health	39.2	66.6	73.8	76.7
Puerto Rico B/S	48.5	76.7	81.4	90.7
Puerto Rico	48.5	76.7	81.5	90.7
Virgin Islands	35.8	64.9	61.9	62.5
Philadelphia region	61.6	81.0	82.0	84.0
Delaware [2]	64.0	80.4	77.8	83.8
District of Columbia B/S [3]	59.6	78.3	78.5	80.5
Maryland B/S	61.9	79.3	81.0	83.1
Pennsylvania B/S	65.7	87.1	88.0	88.9
Virginia—Travelers	52.6	63.0	64.2	69.0
West Virginia—Nationwide	51.0	69.4	71.3	75.9
Atlanta region	52.3	62.5	64.8	70.3

TABLE 4.—NET ASSIGNMENT RATES OF PART B CARRIERS, CALENDAR YEAR 1980 AND FISCAL YEARS 1985, 1986, AND 1987—Continued

Carrier	1980	1985	1986	1987
Alabama B/S	63.9	78.7	76.6	80.3
Florida B/S	38.4	62.2	62.2	67.1
Florida—Group Health	69.5			
Georgia—Prudential	59.6	70.3	69.3	72.7
Kentucky—Metropolitan	54.1	61.2	[5] 63.1	[5] 69.5
Mississippi—Travelers	63.8	67.6	69.1	73.5
North Carolina—Prudential	52.9	64.8	67.3	72.6
South Carolina B/S	57.8	61.1	60.8	66.0
Tennessee—Equitable	54.0	63.6	56.7	67.9
Chicago region	47.6	65.0	65.1	68.7
Illinois—EDSF	43.8	61.1	[6] 61.5	[6] 64.1
Indiana B/S	31.7	54.2	55.6	60.2
Michigan B/S	72.8	87.1	87.5	89.0
Minnesota B/S	23.8	37.9	35.5	43.9
Minnesota—Travelers	32.8	46.8	49.1	58.2
Ohio—Nationwide	37.9	57.0	56.9	63.8
Wisconsin B/S	36.2	57.4	54.1	58.9
Dallas region	50.3	62.3	62.4	67.6
Arkansas B/S	56.0	71.9	71.2	77.6
Louisiana—Pan American	46.9	55.9	[7] 65.0	70.0
New Mexico—Equitable**	44.5	65.5	64.6	**65.1
Oklahoma—Aetna	17.8	47.6	48.6	55.1
Oklahoma—SRS	97.0			
Texas B/S	52.8	63.6	62.5	67.8
Kansas City region	40.4	56.9	57.1	62.9
Iowa B/S	35.9	50.1	46.9	56.5
Kansas B/S	49.1	72.3	69.9	75.2
Missouri B/S	41.0	72.8	72.9	75.6
Missouri—General American	40.1	50.7	53.4	59.2
Nebraska—Mutual of Omaha	33.6	39.5	[8] 40.4	[8] 53.0
Denver region	39.5	52.5	51.4	56.0
Colorado B/S	47.9	61.0	58.7	61.7
Montana B/S	24.5	46.9	41.4	47.3
North Dakota B/S	30.8	36.6	37.5	47.2
North Dakota	33.3	38.8	40.0	50.3
South Dakota	27.0	34.0	34.8	43.9
Utah B/S	44.2	57.8	61.3	65.2
Wyoming—Equitable	18.0	43.3	40.1	41.2
San Francisco region	53.2	70.4	70.4	73.7
Arizona-Nevada—Aetna	31.6	61.7	59.1	63.2
Arizona	28.1	58.3	54.6	59.2
Nevada	46.7	75.8	78.3	81.2
California B/S	65.1	68.6	68.9	70.9
California—Occidental	44.1	74.9	75.1	79.1
Hawaii—Aetna	41.0	63.1	65.9	72.1
Seattle region	31.3	45.7	46.0	51.7
Alaska-Oregon—Aetna	23.4	42.2	43.7	49.7
Alaska	48.8	60.2	61.4	69.5

TABLE 4.—NET ASSIGNMENT RATES OF PART B CARRIERS, CALENDAR YEAR 1980 AND FISCAL YEARS 1985, 1986, AND 1987—Continued

Carrier	1980	1985	1986	1987
Oregon	22.7	41.7	43.1	49.0
Idaho—Equitable	21.3	32.5	31.2	36.5
Washington B/S	37.1	49.8	49.7	55.4
Railroad Retirement Board—Travelers	41.8	57.4	62.4	66.5

*Represents operations under Travelers beginning Nov. 28, 1986.
**Represents operations under Aetna beginning Oct. 1, 1986.
[1] B/S means Blue Shield.
[2] Represents operations under Pennsylvania Blue Shield beginning Aug. 1, 1981.
[3] Represents operations under Pennsylvania Blue Shield beginning Oct. 1, 1981.
[4] 1986 carrier is Massachusetts B/S.
[5] 1986 carrier is Kentucky B/S.
[6] 1986 carrier is Illinois B/S.
[7] 1986 carrier is Lousiana-Arkansas B/S.
[8] 1986 carrier is Iowa B/S.
Source: DHHS, HCFA.

PARTICIPATING PHYSICIAN PROGRAM DATA

For the participation period beginning October 1, 1985, 27.9 percent of physicians billing Medicare were participating, 32.2 percent of limited license practitioners (i.e., chiropractors, dentists, podiatrists) were participating, and 23 percent of Medicare suppliers were participating. For the participation period beginning October 1, 1986, 28.4 percent of physicians (including limited licensed practitioners) were participating and 23.0 percent of suppliers were participating, for an overall participation rate of 27.7 percent.

The overall participation percentages do not vary substantially from fiscal years 1985 to 1986. Approximately 15 percent of fiscal year 1985 participating physicians dropped out of the program in fiscal year 1986. In 1986, there were 13,718 new physician participants and 2,932 new supplier participants.

For the participation period beginning January 1987, overall participation increased over the preceding period. Participation among physicians was 30.1 percent, while 30.4 percent of limited license practitioners participated. Participation among suppliers declined somewhat, from 23 percent in 1986 to 18.3 percent in 1987.

TABLE 5.—PARTICIPATION PERCENTAGE, BY SPECIALTY, FISCAL YEARS 1985 AND 1986, AND CALENDAR YEAR 1987[1]

Specialty	FY 1985 participation percentage	FY 1986 participation percentage	1987 participation percentage
Physicians (M.D.s and D.O.s):			
General Practice	27.3	23.6	25.6
General Surgery	33.9	34.5	37.2
Otology, Laryngology, Rhinology	24.6	25.1	27.0

TABLE 5.—PARTICIPATION PERCENTAGE, BY SPECIALTY, FISCAL YEARS 1985 AND 1986, AND CALENDAR YEAR 1987—Continued

Specialty	FY 1985 participation percentage	FY 1986 participation percentage	1987 participation percentage
Anesthesiology	21.1	21.7	20.3
Cardiovascular Disease	35.6	38.8	43.2
Dermatology	34.0	37.8	38.1
Family Practice	25.5	27.1	27.1
Internal Medicine	32.5	31.1	33.6
Neurology	34.8	33.2	39.2
Obstetrics-Gynecology	29.1	30.5	31.5
Ophthalmology	27.3	28.7	35.1
Orthopedic Surgery	29.0	38.3	32.6
Pathology	39.6	37.7	41.2
Psychiatry	30.0	27.8	28.6
Radiology	41.3	39.5	39.8
Urology	27.8	29.0	30.9
Nephrology	50.8	46.2	49.7
Clinic or Other Group Practice—Not GPPP	33.8	35.4	50.6
Other Medical Specialties	32.4	28.3	30.1
Other Surgical Specialties	18.2	12.7	14.8
Limited License Practitioners (LLP):			
Chiropractor	25.4	23.8	19.7
Podiatry-Surgical Chiropody	38.2	31.8	33.4
Optometrist	44.0	48.2	44.1
Other Limited License Practitioners (Audiologist, psychologist, physical therapist)	36.8	33.8	30.9
Suppliers:			
Independent Laboratory	28.4	36.3	37.2
Durable Medical Equipment Suppliers	22.7	18.7	16.6
Ambulance Service Suppliers	28.6	38.6	27.9
Miscellaneous Suppliers (Orthotists, prosthetists, portable x-ray suppliers)	22.5	22.9	15.5

Source: Health Care Financing Administration.

TABLE 6.—PERCENTAGE OF PHYSICIAN/SUPPLIERS PARTICIPATING BY STATE, FISCAL YEARS 1985 AND 1986, AND CALENDAR YEAR 1987

State	1987 participation			Percent total fiscal year 1986 participation	Percent total fiscal year 1985 participation
	Percent physicians	Percent supplier	Percent total		
Alabama	68.8	25.8	59.5	50.1	50.2
Alaska	27.1	9.1	25.1	11.7	12.2
Arizona	28.1	15.2	27.0	16.1	18.7
Arkansas	42.0	27.0	39.5	41.4	41.9
California	38.9	20.7	37.5	29.4	30.4

TABLE 6.—PERCENTAGE OF PHYSICIAN/SUPPLIERS PARTICIPATING BY STATE, FISCAL YEARS 1985 AND 1986, AND CALENDAR YEAR 1987—Continued

State	1987 participation			Percent total fiscal year 1986 participation	Percent total fiscal year 1985 participation
	Percent physicians	Percent supplier	Percent total		
Colorado	19.5	19.2	19.5	29.9	42.2
Connecticut	17.4	21.3	17.8	22.9	25.8
Delaware	31.2	9.0	27.4	22.6	31.8
District of Columbia	28.0	12.0	26.4	29.0	49.1
Florida	24.9	9.6	21.1	24.0	24.4
Georgia	25.8	32.0	26.7	32.2	33.0
Hawaii	47.8	10.2	44.6	20.7	18.2
Idaho	10.4	2.0	8.8	11.5	13.2
Illinois	26.7	15.1	25.1	21.8	22.7
Indiana	26.9	14.6	24.9	15.8	18.5
Iowa	25.1	23.5	24.7	29.4	34.4
Kansas	51.4	26.6	47.9	42.5	49.6
Kentucky	34.2	24.8	32.9	24.2	23.3
Louisiana	18.1	19.6	18.2	17.7	27.1
Maine	34.2	25.1	32.6	33.1	39.9
Maryland	30.1	20.1	28.8	30.5	30.3
Massachusetts	43.8	29.4	41.9	47.2	47.3
Michigan	32.7	19.7	31.1	42.3	42.3
Minnesota	22.4	16.8	21.5	19.2	19.0
Mississippi	23.6	14.4	21.4	21.2	22.2
Missouri	24.5	14.9	23.6	32.7	32.1
Montana	17.0	11.3	15.5	22.1	18.8
Nebraska	25.7	22.0	24.5	21.3	25.7
Nevada	33.5	15.7	32.0	20.4	32.7
New Hampshire	25.9	23.0	25.4	29.5	30.1
New Jersey	22.7	18.9	22.1	18.2	20.0
New Mexico	20.8	21.4	20.9	18.4	44.6
New York	24.1	28.4	24.5	21.6	22.9
North Carolina	31.4	12.8	28.3	36.9	39.0
North Dakota	20.5	11.4	17.6	13.0	12.8
Ohio	28.9	19.2	27.5	21.3	23.1
Oklahoma	20.8	7.4	17.9	14.1	13.8
Oregon	26.1	13.8	26.1	18.7	17.3
Pennsylvania	38.1	19.5	38.1	47.2	47.9
Rhode Island	50.8	15.5	50.8	43.0	42.0
South Carolina	25.3	11.0	25.3	17.3	16.0
South Dakota	12.7	11.3	12.7	10.3	10.7
Tennessee	43.4	20.7	43.4	22.3	27.3

TABLE 6.—PERCENTAGE OF PHYSICIAN/SUPPLIERS PARTICIPATING BY STATE, FISCAL YEARS 1985 AND 1986, AND CALENDAR YEAR 1987—Continued

State	1987 participation			Percent total fiscal year 1986 participation	Percent total fiscal year 1985 participation
	Percent physicians	Percent supplier	Percent total		
Texas	19.4	10.3	19.4	19.5	20.2
Utah	42.2	23.8	42.2	29.1	31.4
Vermont	34.1	29.4	34.1	40.2	40.9
Virginia	33.6	22.6	33.6	28.2	28.1
Washington	26.9	27.7	26.9	23.0	26.6
West Virginia	37.5	23.7	35.0	22.2	23.1
Wisconsin	35.1	38.0	35.8	30.3	34.4
Wyoming	20.3	11.3	18.1	18.8	26.2
Total	30.6	18.3	29.1	27.7	29.4

Note: Physician data includes M.D.'s, D.O.'s, and limited license practitioners.

Source: Health Care Financing Administration.

REASONABLE CHARGE REDUCTIONS

The difference between the physician's billed charge and Medicare's approved or reasonable charge is referred to as the *reasonable charge reduction.* Reasonable charge reductions were made on 82.5 percent of unassigned claims in 1987. The amount of the reduction was 25.5 percent of billed charges or $31.44 per approved claim. Beneficiaries were liable for these reduction amounts. (Comparable figures were recorded for assigned claims though the beneficiaries were not liable for the reduction amounts.)

The impact of reasonable charge reductions on unassigned claims is spread unevenly across the population. Nationwide, 68 percent of net claims were paid on an assignment basis in 1985. The AMA center for Health Policy Research reported that for physicians who treated some Medicare patients in 1984, 83.9 percent accepted assignment for at least some patients, an increase over the 75.6 percent recorded in 1982. In 1984, 32.1 percent of physicians always accepted assignments and 16.1 percent never accepted assignment. Medicare program data shows significant variations in assignment rates by physician's specialty, place of service, and type of service. In 1983, the overall dollar assignment rate was 51.6 percent. However, of the 19 specialties that accounted for at least 1 percent of Medicare approved charges, 4 had rates of less than 45 percent (anesthesiology, otolargyngalogy, ophthalmology, and general practice). Assignment rates were higher for inpatient physicians services (54.7 percent) than services furnished in physicians offices (40.4 percent). The rates for medical care services (51.8 percent) was slightly higher than the rate for surgical services (50.1 percent).

TABLE 7.—REASONABLE CHARGE REDUCTIONS FOR MEDICARE PART B (EXCLUDES CLAIMS FROM HOSPITAL-BASED PHYSICIANS AND GROUP-PRACTICE PREPAYMENT PLANS) FOR ASSIGNED AND NOT ASSIGNED CLAIMS, FISCAL YEARS 1975, AND 1980–1987

	1975	1980	1981 [1]	1982 [2]	1983 [3]	1984	1985	1986	1987
Percentage of claims reduced:									
Assigned	68.3	80.0	82.7	83.1	82.4	80.3	81.7	82.5	83.0
Not assigned	75.6	83.7	85.7	85.6	83.9	83.1	84.6	84.9	82.5
Percentage reduction in charges for covered services:									
Assigned	16.4	22.5	23.9	24.3	23.8	24.7	27.0	28.4	27.9
Not assigned	16.6	22.3	23.7	24.1	23.1	23.6	25.6	26.6	25.5
Amount reduced per approved claim:									
Assigned	$11.13	$21.81	$25.84	$29.32	$31.20	$32.62	$33.19	$36.43	$36.98
Not assigned	$13.45	$21.96	$25.13	$28.10	$28.48	$29.69	$33.12	$33.15	$31.44

[1] Data excludes Texas Blue Shield for July–September 1981.

[2] Data excludes Texas Blue Shield for October–December 1981.

[3] These data are slightly understated due to underreporting by Equitable.

Source: Department of Health and Human Services, Health Care Financing Administration.

DISTRIBUTION OF PHYSICIAN SERVICES

Tables 8-12 show the distribution of "reasonable charges" or allowed amounts under the CPR system for calendar year 1984 by various categories of services. The figures are tabulations from the 1984 Part B Medicare Annual Data Procedure file, which is a summary of all claims filed with the 56 Medicare carriers and the carriers for Railroad Retirement beneficiaries.

The totals shown will differ from total SMI outlay figures for 1984 shown in the budget for several reasons:

The amounts shown in these tables are allowed amounts, rather than reimbursements—that is, they include both Medicare's and the enrollee's share of reasonable charges.

The amounts shown are for services rendered during calendar year 1984; budget figures are for payments made during the year (sometimes calendar and sometimes fiscal year) regardless of when the services were rendered.

The amounts shown are only for services reimbursed by carriers under the CPR system; hence, they do not include Part B payments to hospital outpatient departments or to risk-based prepaid medical plans.

Further, the amounts shown underestimate what they are supposed to represent by a small amount because some claims for services rendered in 1984 had not been processed by carriers at the time the 1984 files were submitted to HCFA, and because some claims recorded had to be eliminated due to recording errors.

Table 8 illustrates that in 1984, 85 percent of allowed amounts under the CPR system were for physicians' services, and another 4 percent were for the services of limited license practitioners—psychologists, podiatrists, optometrists, audiologists, chiropractors, dentists, and physical therapists. Less than 2 percent went to independent laboratories in 1984, while nearly 10 percent went to suppliers of medical equipment, prosthetics, and ambulance services.

About 50 percent of all CPR allowed amounts were for hospital inpatient services, and nearly 60 percent of allowed amounts for physicians' services were inpatient. The share of physicians' services that are inpatient has dropped in recent years, from nearly 64 percent in 1981, while the share of services provided in hospital outpatient departments or ambulatory surgicenters has increased—from 4.7 percent in 1981 to 8.6 percent in 1984.

Table 9 shows the distribution of spending for physicians' services by specialty. (It excludes limited license practitioners, labs, and suppliers.) In 1984, generalists accounted for nearly 35 percent of spending, nonsurgical specialists for 14 percent, and surgical specialists for 36 percent. Radiologists, anesthesiologists, and pathologists (RAPs) together accounted for 14 percent of allowed amounts, although they accounted for a higher share of submitted charges (15.5 percent). This disparity may be due to the difficulty carriers have had in developing appropriate fee screens for hospital-based physicians, following elimination of the hospital-physician combined-billing option as of October 1983. Osteopathic physicians accounted for less than 1 percent of total allowed amounts for physicians' services.

The major physician specialties treating the Medicare population, in descending order of importance as measured by total allowed amounts, were general internists (19 percent of allowed amounts), ophthalmologists (11 percent), general surgeons (9 percent), radiologists (8 percent), and general practitioners and cardiologists (each about 6 percent).

The share of services provided on an inpatient basis varied by specialty, generally increasing with specialization. About 48 percent of the services of generalists were inpatient in 1984. The inpatient share was 60 percent for nonsurgical specialists and nearly 67 percent for surgical specialists.

Table 10 shows the distribution of spending for physicians' services by type of service. About 36 percent of spending was for medical care (nonsurgical) in 1984. About 41 percent of spending was for surgical procedures in total, adding together the amounts for surgeons, assistant surgeons, and anesthesiologists. About 7 percent was for diagnostic laboratory tests, which would include not only blood chemistry analysis and urinalysis, but also tests such as EKGs. More than 10 percent of spending was for radiology, and nearly 4 percent was for consultations.

Table 11 lists the top 20 individual services, ranked by total allowed amounts on claims submitted by selected physicians for 1984. Certain physician specialties were excluded when recorded fees were unreliable for any reason. The following groups were excluded: unidentified physicians billing from multispecialty groups, radiologists, anesthesiologists, pathologists, psychiatrists, pediatricians, and osteopaths. The most important exclusion is amounts for the services of anesthesiologists, since there would typically be a charge for anesthesiology for the surgical procedures included in Table 13. The amounts for surgical procedures include claims by both the primary surgeon and any assistant surgeons, but not the amounts for anesthesiologists.

The top 20 services (out of more than 7,000) accounted for 35 percent of all spending for all physicians' services in 1984. Cataract extraction with implantation of an intraocular lens was the top-ranked procedure, accounting by itself for more than 5 percent of total allowed amounts for physicians' services. Other surgical procedures in the top 20 included transurethral resections of the prostate (TURP), hip replacement or arthroplasty, coronary artery bypass surgery, thromboendarterectomy, and repair of a femoral fracture. The remaining services in the top 20 were either visits, consultations, or EKGs.

Table 12 presents total allowed amounts for selected groups of generic services, and shows the percent of total allowed amounts for all physicians' services accounted for by each group. As in Table 11, certain physicians' services—most notably for anesthesiologists—are not included in the allowed amounts for each service group. No attempt was made to define and rank all possible service groups, so that there may be other important service groups that do not appear in the table. For example, diagnostic radiology accounts for more than 9 percent of allowed amounts for physicians' services (from Table 10), but radiological services do not appear in Table 12 because radiologists were one of the specialties eliminated before calculating allowed amounts by service code.

The 21 service groups shown in table 12 accounted for more than 46 percent of all allowed amounts for all physicians' services in 1984. The single most costly group was for hospital visits (accounting for nearly 14 percent of total allowed amounts for physicians' services), followed by office visits (11 percent). Cataract surgery of all types accounted for 6.5 percent of total allowed amounts for physicians' services, compared to 5.2 percent for the single most common cataract procedure shown in table 13. EKGs accounted for 2.6 percent of total allowed amounts when all codes for the procedure are considered, compared to only 1.6 percent of allowed amounts accounted for by the single most common EKG code billed.

TABLE 8.—ALLOWED AMOUNTS FOR CPR CLAIMS, BY TYPE OF PROVIDER, 1984

Type of provider	Allowed amounts (millions)	Percent of total	Percent inpatient
Physicians	$17,326.8	85.0	59.0
Limited license practitioners [1]	797.8	3.9	10.2
Laboratories	362.7	1.8	1.0
Medical suppliers [2]	1,896.8	9.3	.8
All providers [3]	20,384.0	100.0	50.6

[1] Includes psychology, podiatry, optometry, audiology, chiropractice, dentistry, and physical therapy.

[2] Includes suppliers of medical equipment prosthetics, and ambulance services.

[3] Total does not include charges for hospital outpatient department facility fees or for risk-based prepaid medical plans since these are not reimbursed under the CPR system.

Source: CBO tabulations from 1984 pt. B medicare annual data procedure file.

TABLE 9.—ALLOWED AMOUNTS FOR PHYSICIANS' SERVICES, BY PHYSICIAN SPECIALTY, 1984

Specialty	Allowed amounts (millions)	Percent of total	Percent inpatient
Generalists:			
General practice	$1,070.7	6.2	36.3
Family practice	678.3	3.9	38.5
Internal medicine	3,215.5	18.6	51.9
Pediatrics	14.2	.1	34.5
Clinics	1,034.0	6.0	52.9
All generalists	6,012.7	34.7	47.7
Nonsurgical specialists:			
Allergy	86.0	.5	54.2
Cardiology	1,020.4	5.9	66.8
Dermatology	229.6	1.3	3.7
Gastroenterology	274.2	1.6	66.5
Neurology	223.9	1.3	64.8
Psychiatry	225.2	1.3	69.3

TABLE 9.—ALLOWED AMOUNTS FOR PHYSICIANS' SERVICES, BY PHYSICIAN SPECIALTY, 1984—Continued

Specialty	Allowed amounts (millions)	Percent of total	Percent inpatient
Physical medicine	57.5	.3	64.9
Pulmonary disease	196.2	1.1	78.6
Geriatrics	1.4	(1)	42.9
Nephrology	162.0	.9	51.9
All nonsurgical specialists	2,476.4	14.3	60.4
Surgical specialists:			
General surgery	1,507.7	8.7	81.5
Otolaryngology	193.2	1.1	41.9
Neurosurgery	198.3	1.1	85.6
Gynecology	133.4	.8	63.9
Ophthalmology	1,936.6	11.2	42.0
Orthopedic surgery	943.4	5.4	73.6
Plastic surgery	79.8	.5	54.1
Colon and rectal surgery	30.5	.2	57.7
Thoracic surgery	618.9	3.6	92.5
Urology	626.2	3.6	74.6
Hand surgery	3.4	(1)	61.8
All surgical specialists	6,271.4	36.2	66.6
Radiology	1,438.9	8.3	51.0
Anesthesiology	833.3	4.8	93.4
Pathology	164.3	.9	72.2
Osteopathy	129.8	.7	32.8
All physicians	17,326.8	100.0	59.0

[1] Less than 0.05 percent.

Source: CBO tabulations from 1984 pt. B medicare annual data procedure file.

TABLE 10.—ALLOWED AMOUNTS FOR PHYSICIANS' SERVICES, BY TYPE OF SERVICE, 1984

Type of service	Allowed amounts (millions)	Percent of total	Percent inpatient
Medical care	$6,315.3	36.4	49.3
Surgery	5,888.1	34.0	75.9
Assistance at surgery	314.8	1.8	89.2
Anesthesia	840.3	4.8	94.2
Diagnostic laboratory tests	1,240.8	7.2	26.6
Diagnostic radiology	1,578.5	9.1	44.3
Therapeutic radiology	235.1	1.4	18.5

TABLE 10.—ALLOWED AMOUNTS FOR PHYSICIANS' SERVICES, BY TYPE OF SERVICE, 1984—Continued

Type of service	Allowed amounts (millions)	Percent of total	Percent inpatient
Consultations [1]	621.6	3.6	77.7
Other [2]	292.3	1.7	2.8
All services	17,326.8	100.0	59.0

[1] Includes first and second opinions for surgery.

[2] Includes treatment for renal patients, pneumococcal vaccine, and medical supplies, among other things.

Source: CBO tabulations from 1984 pt. B medicare annual data procedure life.

TABLE 11.—THE TOP 20 SERVICES BILLED BY PHYSICIANS UNDER MEDICARE, 1984

Service code and description	Allowed amounts (millions) [1]	Percent of total [2]
Top 20 services:		
66980—Cataract extraction and IOL	$894.4	5.2
90250—Hospital visit, limited	652.5	3.8
90260—Hospital visit, intermediate	631.0	3.6
90060—Office visit, intermediate	593.2	3.4
90050—Office visit, limited	502.8	2.9
90220—Initial hospital visit, comprehensive	329.7	1.9
90240—Hospital visit, brief	293.4	1.7
90620—Consultation, comprehensive	289.8	1.7
52601—TURP	237.2	1.4
90040—Office visit, brief	221.7	1.3
93000—EKG (12 leads)	217.1	1.3
90270—Hospital visit, extended	182.2	1.1
90070—Office visit, extended	145.4	.8
27130—Hip replacement	135.6	.8
90020—Office visit, comprehensive, new patient	127.0	.7
90080—Office visit, comprehensive	127.0	.7
33512—Coronary artery bypass (3)	124.6	.7
35301—Thromboendarterectomy	104.2	.6
27244—Femoral fracture	104.1	.6
90215—Initial hospital visit, intermediate	102.5	.6
Sum	6,015.3	34.7

[1] Amounts for surgical procedures include fees for primary and assistant surgeons, but not for anesthesiologists. Allowed amounts for services in carrier regions that were using HCPCS were inflated to account for service totals in the 7 carrier regions that were not using HCPCS in 1984.

[2] The total allowed amount for all physicians' services in all carrier regions in 1984 was $17,326.8 million.

Source: CBO tabulation from 1984 medicare annual data procedure file.

TABLE 12.—ALLOWED AMOUNTS FOR SELECTED GROUPS OF PHYSICIANS' SERVICES, 1984

Service group	Allowed amounts (millions) [1]	Percent of total [2]
Hospital visits	$2,372.7	13.7
Office visits	1,938.6	11.2
Cataract surgery	1,126.2	6.5
EKG's	453.3	2.6
Transurethral surgery	340.3	2.0
Coronary artery bypass	308.9	1.8
Hip arthroplasty	192.0	1.1
Cardiac catheterization	166.0	1.0
Colonoscopy	163.7	.9
Hemodialysis/capd	147.5	.9
Thromboendarterectomy	126.7	.7
Knee arthroplasty	110.3	.6
Pacemaker implant/removal	109.6	.6
Vein bypass	102.5	.6
Emergency room visits	94.7	.5
SNF visits	87.2	.5
Nursing home visits	81.4	.5
Home visits	43.5	.3
Prostatectomy	25.4	.1
EEG's	18.1	.1
Pacemaker tests	16.2	.1
Sum	8,024.6	46.3

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[1] Amounts for surgical procedures include fees for primary and assistant surgeons, but not for anesthesiologists. Allowed amounts for services in carrier regions that were using HCPCS were inflated to account for service totals in the seven carrier regions that were not using HCPCS in 1984.

[2] The total allowed amount for all physicians' services in all carrier regions in 1984 was $17,326.8 million.

Source: CBO tabulation from 1984 medicare annual data procedure file.

Section 5. Trade Adjustment Assistance

The trade adjustment assistance (TAA) programs were first established under the Trade Expansion Act of 1962 for the purpose of assisting in the special adjustment problems of workers and firms dislocated as a result of a Federal policy of reducing barriers to foreign trade. As a result of limited eligibility and usage of the programs, criteria and benefits were liberalized under title II of the Trade Act of 1974, Public Law 93-618. The Omnibus Budget Reconciliation Act of 1981 (OBRA), Public Law 97-35, reformed the program for workers as proposed by the Administration. The amendments, particularly in program eligibility and benefits, were intended to reduce program cost significantly and to shift its focus from income compensation for temporary layoffs to return to work through training and other adjustment measures for the long-term or permanently unemployed. The OBRA also made relatively minor modifications in the firm program. Most amendments became effective on October 1, 1981. Both programs were extended at that time for 1 year, to terminate on September 30, 1983.

Public Law 98-120 (H.R. 3813 as amended by the Senate), approved on October 12, 1983, extended the worker and firm TAA programs for 2 years until September 30, 1985. Sections 2671-2673 of the Deficit Reduction Act of 1984, Public Law 98-369, included three provisions (sections 3, 6, and 8 of H.R. 3391 as passed by the House on September 15, 1983) which amended the program for workers to increase the availability of worker training allowances and the level of job search and relocation benefits, and amended the program for firms to increase the availability of industrywide technical assistance.

The termination date of the worker and firm TAA programs was further extended under temporary legislation in the first session of the 99th Congress (Public Laws 99-107, 99-155, 99-181, and 99-189) until December 19, 1985. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Public Law 99-272 approved April 7, 1986, reauthorized the TAA programs for workers and firms for 6 years retroactively from December 19, 1985, until September 30, 1991, with amendments.

H.R. 3, the omnibus trade bill currently in conference, contains significant House and Senate amendments to be reconciled concerning eligibility coverage, benefit criteria, administration, and funding of the TAA programs for workers and firms. The Senate-passed bill would also extend program authorization for 2 additional years until September 30, 1993.

TRADE ADJUSTMENT ASSISTANCE PROGRAM FOR WORKERS

Trade adjustment assistance for workers under sections 221 through 250 of the Trade Act of 1974, as amended, consists of trade readjustment allowances (TRA), employment services, training and extended TRA allowances while in training, and job search and relocation allowances for certified and otherwise qualified workers. The program is administered by the Employment and Training Administration (ETA) of the Department of Labor through State employment security agencies under cooperative agreements between each State and the Secretary of Labor. ETA processes petitions and issues certifications or denials of petitions by groups of workers for eligibility to apply for TAA. The State agencies act as Federal agents in processing applications and determining individual worker eligibility for benefits, issuing payments, and providing reemployment services and training opportunities.

TABLE 1.—NUMBER OF PETITIONS INSTITUTED AND CERTIFIED AND ESTIMATED NUMBER OF WORKERS PETITIONING AND CERTIFIED FOR TRADE ADJUSTMENT ASSISTANCE, TOTAL AND BY INDUSTRY FROM APRIL 1975 THROUGH DECEMBER 31, 1987

Year	Cases instituted		Cases certified		
	Petitions	Estimated workers	Petitions	Percent[1]	Estimated workers
1975	528	210,988	121	50	54,843
1976	1,014	218,541	430	45	143,578
1977	1,289	227,562	411	38	143,714
1978	1,732	171,315	854	42	164,416
1979	2,119	320,707	844	41	221,474
1980	5,347	1,027,214	935	29	585,378
1981	1,134	132,222	260	9	32,991
1982	1,030	170,036	254	20	20,004
1983	959	163,929	482	34	57,150
1984	504	42,902	337	52	15,367
1985	1,392	145,863	491	60	28,824
1986	1,774	201,348	829	45	133,972
1987	1,535	168,619	681	39	85,861
Total	20,357	3,201,246	6,929	34	1,687,572

[1] Estimated percent of petitioning workers covered by completed cases; figures are not precise but indicate the trend.

Certification requirements

A two-step process is involved in the determination of whether an individual worker will receive trade adjustment assistance: (1) certification by the Secretary of Labor of a petitioning group of workers in a particular firm as eligible to apply; and (2) approval by the State agency administering the program of the application for benefits of an individual worker covered by a certification.

The process begins by a group of three or more workers, their union, or authorized representative filing a petition with the ETA for group eligibility. To certify a petitioning group of workers as eligible to apply for adjustment assistance, the Secretary must determine that three conditions are met:

1. A significant number or proportion of the workers in the firm or subdivision of the firm have been or are threatened to be totally or partially laid off;
2. Sales and/or production of the firm or subdivision have decreased absolutely; and
3. Increased imports of articles like or directly competitive with articles produced by the firm or subdivision of the firm have "contributed importantly" to both the layoffs and the decline in sales and/or production.

	Thousands
Total estimated number of workers certified	1,688
Industry:	
Automobiles	745
Apparel	193
Steel	172
Footwear	98
Electronics	84
Fabricated metal products	49
Textiles	31

Source: Department of Labor.

Eligibility requirements for trade readjustment allowances

In order to receive entitlement to a trade readjustment allowance for any week of unemployment, an individual worker covered by a certification must file an application with his State employment security office and meet the following eligibility requirements:

1. The worker's last total or partial layoff before application must have occurred not more than 1 year prior to the date of the petition, on or after the "impact date" (i.e., the date on which total or partial layoffs began or threatened to begin), within 2 years after the date the Secretary of Labor issued the certification covering the worker, and before the termination date (if any) of the certification; and
2. The worker was employed at least 26 of the 52 weeks preceding last layoff in adversely affected employment with a single firm or subdivision thereof at wages of $30 or more per week.

As amended in 1986, a week of employment includes the week in which layoff occurs and up to 7 weeks of employer-authorized vacation, sick, injury, maternity, or military leave, or service as a full-time union representative. Weeks of disability covered by workmen's compensation may also count toward the 26-week minimum.

In addition, the OBRA amended the program to include the following TRA eligibility limitations:

1. Under the program prior to October 1, 1981, TRA benefits were a supplement to state unemployment insurance and paid concurrently during weeks the worker was eligible for UI. A fundamental change under the current program makes TRA

benefits a continuation of the UI program by requiring the worker to exhaust all rights to UI, including any extended benefits (EB) or Federal supplemental compensation (FSC) (if in existence), to which the worker is entitled in the most recent benefit period before becoming eligible for any TRA payments. The worker is also ineligible for TRA benefits for any subsequent week of entitlement to payment for any further UI or waiting period credit.

2. All TRA claimants in all States are subject to the provisions of the EB "suitable work" test under section 202(a)(3) of the Federal-State Extended Unemployment Compensation Act of 1970 after the end of their regular UI benefit period as a precondition for receiving any weeks of TRA payments. Workers are not disqualified for TRA benefits if in State-approved training prior to eligibility or for any form of TAA because of subsequently leaving employment which is not of a substantially equal or higher skill and wage level than previous employment.
3. Workers are entitled to TRA payments only for weeks of unemployment which begin more than 60 days after the filing date of the petition, i.e. after the statutory deadline for certification. Workers can be certified for layoffs occurring up to 1 year prior to the petition filing date in order to qualify for other TAA benefits, but can no longer receive TRA payments retroactively for weeks prior to the date certification is supposed to take place.
4. No TRA payment can be made for a UI waiting week.
5. As an incentive to early reemployment, the 1986 amendments require, as a prerequisite for receiving TRA payments, that workers be enrolled in or have completed a job search program approved by the Secretary of Labor in order to receive TRA payments, unless the Secretary has determined that no acceptable job search program is reasonably available.

As a further encouragement to reemployment, the Secretary of Labor may require all workers in a labor market area with certain economic characteristics either to accept training or to extend job search beyond their labor market area after their first 8 weeks of TRA eligibility if they have been approved for training.

Benefit levels and duration

TRA benefits prior to October 1, 1981, were 70 percent of the worker's former gross weekly wage not to exceed the average weekly manufacturing wage, reduced by the amount of his unemployment compensation entitlement, 50 percent of any part-time earnings, and certain training allowances paid under Federal law. Eligible workers could collect basic benefits for up to 52 weeks of unemployment during a maximum two-year period following layoff.

The following major changes under the OBRA, effective as of October 1, 1981, reduced program costs and were intended to remove reemployment disincentives associated with the previous high net wage replacement and the inequity in benefit amounts between import-impacted workers and workers laid off for other reasons:

1. The TRA weekly benefit amount is the same as, and a continuation of, the claimant's unemployment insurance weekly

benefit amount during the most recent UI benefit period, reduced by any training allowance and disqualifying income deductible under UI law. This change has shifted the TRA benefit level from a uniform national standard to a State standard.

2. The total amount of basic TRA benefits payable to a worker is a maximum of 52 times the TRA allowance level for a week of total unemployment minus the total amount of UI benefits payable in the worker's most recent benefit period (e.g., a worker receiving 39 weeks of UI regular and extended benefits could receive a maximum 13 weeks of TRA benefits). UI and TRA payments combined are limited to a maximum 52 weeks in all cases involving extended benefits. As amended in 1986, TRA basic benefits may be collected only during the 104-week period (compared to 52-week period previously) following the week in which the worker has exhausted all rights to regular unemployment compensation in the most recent benefit period.

3. Workers may receive up to 26 additional weeks of TRA benefits to assist in completing approved training, if the worker applies for the training program within 210 days after certification or layoff, whichever date is later. The additional benefits may be collected only during the 26-week period following the worker's last week of entitlement to basic TRA benefits. As amended in 1984, if training has not been approved until after the last week of entitlement to basic TRA, the 26-week collection period begins with the first week the worker enters training. Workers cannot receive a TRA payment for any week during which they receive on-the-job training.

TABLE 2.—TOTAL OUTLAYS FOR TRADE READJUSTMENT ALLOWANCES, NUMBER OF RECIPIENTS, AVERAGE WEEKLY PAYMENTS AND DURATION, FISCAL YEARS 1976 THROUGH 1987

Fiscal year	Total outlays (millions)	Total number of recipients (thousands)	Average weekly payment per recipient	Average week's duration
1975 (4th quarter)	$71	47	$58	26.0
1976 [1]	79	62	47	27.3
1977	148	111	57	23.4
1978	257	156	68	24.3
1979	256	132	70	27.4
1980	1,622	532	126	24.1
1981	1,440	281	140	36.5
1982	103	30	119	28.4
1983	37	30	120	10.1
1984	35	16	139	16.0
1985	43	20	133	15.1
1986	116	40	144	[2] 19.0
1987	[2] 198	[2] 50		
Total	[2] 4,405	[2] 1,507		

[1] Fiscal year 1976 is the first full year of experience under the program as amended by the Trade Act of 1974.

[2] Estimated.

Note: The above figures relate only to trade readjustment allowances; administrative expenses and outlays for employment services, training, and job search and relocation allowances are not included.

Source: Department of Labor.

Training and other employment services, job search and relocation allowances

Training and other employment services and job search and relocation allowances are available through State agencies to certified workers whether or not they have exhausted UI benefits and become eligible for TRA payments.

Employment services consist of counseling, vocational testing, job search and placement, and other supportive services, as appropriate.

Training, preferably on-the-job, shall (to the extent appropriated funds are available) be approved [1] for a worker if the following five conditions are met: (1) there is no suitable employment available; (2) the worker would benefit from appropriate training; (3) there is a reasonable expectation of employment following training completion; (4) approved training is available from government agencies or private sources; and (5) the worker is qualified to undertake and complete such training. While training itself is not an entitlement, if training is approved, a worker is entitled to payment of the costs, unless they have been paid or are reimbursable under another Federal law. As a result, the Department of Labor prohibits State agencies from approving training if sufficient funds have not been appropriated and allocated to pay the costs. On-the-job training costs are payable only if such training is not at the expense of currently employed workers.

Supplemental assistance is available to defray reasonable transportation and subsistence expenses for separate maintenance when training is not within the worker's commuting distance, equal to the lesser of actual per diem expenses or 50 percent of the prevailing Federal per diem rate for subsistence and prevailing mileage rates under Federal regulations for travel expenses.

Job search allowances are available to certified workers who cannot obtain suitable employment within their commuting area, are totally laid off, and who apply within 1 year after certification or last total layoff, whichever is later, or within 6 months after concluding training. As amended in 1981 and 1984, the allowance for reimbursement is equal to 90 percent of necessary job search expenses, based on the same increased supplemental assistance rates described above, up to a maximum amount of $800. The 1986 amendments require the Secretary of Labor to reimburse workers for necessary expenses incurred to participate in an approved job search program.

Relocation allowances are available to certified workers totally laid off at time of relocation who have been able to obtain an offer of or actual suitable employment only outside their commuting area, who apply within 14 months after certification or last total layoff, whichever is later, or within 6 months after concluding training, and whose relocation takes place within 6 months after application or completion of training. As amended in 1981 and 1984, the allowance is equal to 90 percent of reasonable and necessary expenses for transporting the worker, family, and household effects, based on the same increased supplemental assistance rates described above, plus a lump sum payment of three times the worker's average weekly wage up to a maximum amount of $800.

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[1] Prior to the 1986 amendments the Secretary was authorized, rather than required, to approve training if the five statutory criteria are met, subject to the availability of funds.

TABLE 3.—TRAINING, JOB SEARCH, AND RELOCATION ALLOWANCES: TOTAL NUMBER OF WORKERS AND OUTLAYS, FISCAL YEARS 1976 THROUGH 1987

Fiscal year	Total number			Total outlays (millions) [1]
	Entered training	Job searches	Relocations	
1975 (4th quarter)	463	158	44	
1976	823	23	26	$2.7
1977	4,213	277	191	4.0
1978	8,337	1,072	631	12.8
1979	4,458	1,181	855	13.5
1980	[2] 9,475	931	629	6.0
1981	[2] 20,386	1,491	2,011	4.2
1982	5,844	697	662	19.4
1983	11,299	696	3,269	36.0
1984	6,821	799	2,220	19.0
1985	7,424	916	1,692	30.2
1986	9,400	1,053	1,844	29.9
1987	[3] 10,588	[3] 2,165	[3] 1,893	49.9
Total	99,531	11,459	15,967	227.6

[1] Excludes administrative costs.

[2] Of total workers entering training, 5,640 (59 percent) in 1980 and 18,940 (94 percent) in 1981 self-financed their training costs.

[3] Estimated.

Source: Department of Labor.

Funding

Federal funds, as an entitlement from general revenues under the Federal Unemployment Benefit Account (FUBA) in the Department of Labor, cover only the portion of the worker's total entitlement represented by the continuation of UI benefit levels in the form of TRA payments, plus the salaries and expenses for ETA personnel administering the program. Funds made available under grants to States defray expenses of any employment services. Funding for training, job search and relocation allowances, and related expenses is subject to annual appropriations for the Department of Labor.

For fiscal year 1988, $47,870,000 is appropriated for training and job search and relocation allowances, including necessary related administrative expenses. Estimated outlays for trade readjustment allowance payments in fiscal year 1988 total $138 million.

The States are reimbursed from Treasury general revenues for benefit payments and other costs incurred under the program. A penalty under section 239 of the Trade Act of 1974 provides for reduction by 15 percent of the credits for State unemployment taxes which employers are allowed against their liability for Federal unemployment tax if a State has not entered into or has not fulfilled its commitments under a cooperative agreement.

TRADE ADJUSTMENT ASSISTANCE PROGRAM FOR FIRMS

Section 251 through 264 of the Trade Act of 1974, as amended, contain the procedures, eligibility requirements, benefits and their terms and conditions, and administrative provisions of the trade adjustment assistance program for firms adversely impacted by increased import competition. Administration of the program was transferred in 1982 within the Department of Commerce from the Economic Development Administration to the International Trade Administration. Amendments in 1986 under the COBRA eliminated financial assistance (direct loan or loan guarantee) benefits, increased government participation in technical assistance, and expanded the criteria for firm certification.

Program benefits now consist of technical assistance for petitioning firms which qualify under a two-step procedure: (1) certification by the Secretary of Commerce that the petitioning firm is eligible to apply, and (2) approval by the Secretary of Commerce of the application by a certified firm for benefits, including the firm's proposal for economic adjustment.

To certify a firm as eligible to apply for adjustment assistance, the Secretary must determine that three conditions are met:

1. A significant number or proportion of the workers in the firm have been or are threatened to be totally or partially laid off;
2. Sales and/or production of the firm have decreased absolutely, or sales and/or production that accounted for at least 25 percent of total production or sales of the firm during the 12 months preceding the most recent 12-month period for which data are available have decreased absolutely; and
3. Increased imports of articles like or directly competitive with articles produced by the firm have "contributed importantly" to both the layoffs and the decline in sales and/or production.

A certified firm may file an application with the Secretary of Commerce for trade adjustment assistance benefits at any time within 2 years after the date of the certification of eligibility. The application must include a proposal by the firm for its economic adjustment. The Secretary may furnish technical assistance to the firm in preparing its petition for certification and/or in developing a viable economic adjustment proposal.

The Secretary approves the firm's application for assistance only if he determines that its adjustment proposal (a) is reasonably calculated to make a material contribution to the economic adjustment of the firm; (b) gives adequate consideration to the interests of the workers in the firm; and (c) demonstrates that the firm will make all reasonable efforts to use its own resources for economic development.

Benefits

Technical assistance may be given to implement the firm's economic adjustment proposal in addition to, or in lieu of, precertification assistance or assistance in developing the proposal. It may be furnished through existing government agencies or through private individuals, firms, and institutions (including private consulting services), or by grants to intermediary organizations, including regional Trade Adjustment Assistance Centers. As amended by the COBRA, the Federal Government may bear the full cost of technical assistance to a firm in preparing its petition for certification. However, the Federal share cannot exceed 75 percent of the cost of assistance furnished through private individuals, firms, or institutions for developing or implementing an economic adjustment proposal. Grants may be made to intermediate organizations to defray up to 100 percent of their administrative expenses in providing technical assistance.

As amended in 1984, the Secretary of Commerce also may provide technical assistance of up to $10 million annually per industry to establish industrywide programs for new product or process development, export development, or other uses consistent with adjustment assistance objectives. The assistance may be furnished through existing agencies, private individuals, firms, universities, and institutions, and by grants, contracts, or cooperative agreements to associations, unions, or other nonprofit organizations of industries in which a substantial number of firms or workers have been certified.

Funding

Funds to cover all costs of the program are subject to annual appropriations to the International Trade Administration of the Department of Commerce from general revenues. For fiscal year 1988, a total of $14.4 million was appropriated for the program.

Since April 1975, approximately 3,000 firms have received TAA certification. About 5,500 firms have received one or more forms of technical assistance totaling about $150 million. Prior to April 7, 1986, about 340 firms received financial assistance totaling about $385 million.

Section 6. Unemployment Compensation

OVERVIEW

The Social Security Act of 1935 (Public Law 74-271) created the Federal-State unemployment compensation (UC) system. It has two main objectives: (1) to provide temporary and partial wage replacement to involuntarily unemployed workers who were recently employed; and (2) to help stabilize the economy during recessions. The U.S. Department of Labor oversees the system, but each State administers its own program. Because Federal law defines the District of Columbia, Puerto Rico, and Virgin Islands as "States" for the purposes of unemployment compensation, there are 53 State programs.

The Federal Unemployment Tax Act of 1939 (Public Law 76-379) and titles III, IX, and XII of the Social Security Act form the framework of the system. The Federal Unemployment Tax Act (FUTA) currently imposes a 6.2 percent gross tax rate on the first $7,000 paid annually by covered employers to each employee. Employers in States with programs approved by the Federal Government and with no delinquent Federal loans may credit 5.4 percentage points against the 6.2 percent tax rate, making the minimum, net Federal unemployment tax rate 0.8 percent. This Federal revenue finances administration of the system, half of the Federal-State extended benefits program, and a Federal account for State loans. In theory, the States are supposed to use the revenue turned back to them by the 5.4 percent credit to finance their regular State programs and half of the Federal-State extended benefits program.

In 1976 Congress passed a temporary surtax of 0.2 percent of taxable wages to be added to the permanent FUTA tax rate (Public Law 94-566). Thus, the current 0.8 percent FUTA tax rate has two components: a permanent tax rate of 0.6 percent and a temporary surtax rate of 0.2 percent. Under the Ominibus Budget Reconciliation Act of 1987 (P.L. 100-203), the 0.2 percent surtax was extended for 3 years through 1990.

TABLE 1.—UNEMPLOYMENT COMPENSATION PROGRAM STATISTICS

	Fiscal year—											
	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988 (estimate) [2]	1989 (projected) [2]
Total civilian unemployment rate (percent)	6.2	5.8	6.8	7.3	9.1	10.1	7.8	7.2	7.0	6.4	5.9	5.8
Insured unemployment rate (percent) [1]	3.5	3.1	3.8	3.5	4.4	4.3	2.9	2.9	2.8	2.5	2.2	2.2
Coverage (millions of individuals)	79.9	86.1	87.0	88.2	86.8	86.3	89.9	93.0	95.7	97.9	100.0	101.6
Average weekly benefit amount (dollars)	80	85	96	102	114	120	119	122	129	135	140	146
State unemployment compensation:												
Beneficiaries (millions of individuals)	7.7	7.8	9.9	8.8	11.4	9.9	7.6	8.4	8.3	7.5	7.1	7.4
Regular benefit exhaustions (millions of individuals)	2.2	2.0	2.7	3.2	3.7	4.6	2.8	2.6	2.8	2.6	2.1	2.2
Regular benefits paid (billions of dollars)	8.32	8.74	12.95	13.46	19.34	20.84	13.3	14.3	15.6	15.0	13.6	14.4
Extended benefits (State share: billions of dollars)	.51	.12	.56	1.06	.93	1.21	.03	.03	.05	.04	.01	.01
State tax collections (billions of dollars)	11.03	12.27	11.91	12.37	12.77	14.43	19.04	20.01	18.8	19.1	17.5	16.4
State trust fund impact (income-outlays: billions of dollars)	+2.20	+3.41	−1.60	−2.15	−7.50	−7.62	+5.70	+5.65	+3.17	+4.11	+3.86	+1.96
Federal unemployment compensation accounts:												
Federal tax collections (billions of dollars) [3]	2.60	2.91	3.19	3.26	3.18	3.58	5.02	4.44	4.08	5.08	5.48	5.73
Outlays: Federal extended benefits share plus Federal supplemental benefits (billions of dollars)	.69	.12	.56	1.06	.97	6.80	3.01	.03	.05	.04	.01	.01
Administrative costs (billions of dollars):												
Unemployment Insurance Service	.93	.97	1.15	1.32	1.42	1.70	1.58	1.58	1.57	1.56	1.66	1.68
Employment Service [4]	.64	.70	.73	.73	.68	.72	.76	.92	.93	.90	.95	.90
Total administrative costs	1.57	1.67	1.88	2.05	2.10	2.42	2.31	2.50	2.50	2.46	2.61	2.58

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[1] The average number of workers claiming State unemployment compensation benefits as a percent of all workers covered.

[2] Based on President's 1988 budget.

[3] Net of reduced credits.

[4] Includes Bureau of Labor Statistics and Veterans' Employment Service.

Sources: Office of Research, Legislation and Program Policies/ETA/UIS/DOL, Division of Actuarial Services, and U.S. Budget Appendixes.

The Federal Unemployment Tax Act (FUTA) determines covered employment. FUTA also imposes certain requirements on the State programs, but the States generally determine individual qualification requirements, disqualification provisions, eligibility, weekly benefit amounts, potential weeks of benefits, and the State tax structure used to finance all of the regular State benefits and half of the extended benefits.

The Social Security Act provides for the administrative framework. Title III authorizes Federal grants to the States for administration of the State UC laws. Title IX authorizes the various components of the Federal Unemployment Trust Fund. Title XII authorizes advances or loans to insolvent State UC programs.

The Unemployment Trust Fund

The Federal unified budget accounts for all Federal-State UC outlays and taxes in the Federal Unemployment Trust Fund. The Unemployment Trust Fund has 59 accounts. The accounts consist of 53 State UC program accounts, the Railroad Unemployment Insurance Account, Railroad Administration Account, and four Federal accounts. The status of each State program account at the beginning of fiscal year 1987 is shown in table 2.

The economic expansion has improved the fiscal condition of the unemployment trust fund. State debt declined from $4.8 billion at the beginning of fiscal year 1987 to $2.9 billion at the beginning of fiscal year 1988. The number of States with Federal loans decreased from 10 to 5 over the same time period. Balances as a percent of total wages in a State increased in 39 States and either declined or remained constant in the remaining States. Balances as a percent of total wages in a State ranged from −0.4 percent in Texas to 3.3 percent in Puerto Rico. A balance of 2.0 percent of total wages paid in a State would help most States to avoid borrowing during a recession. In the aggregate, reserves were at 1.2 percent of wages paid in the United States.

TABLE 2.—STATE UNEMPLOYMENT TRUST FUND ACCOUNT BALANCES AT THE BEGINNING OF FISCAL YEAR 1988

[Dollars in millions]

State	1988 beginning balance	Minus loans outstanding at beginning of 1988	1988 adjusted beginning balances	Adjusted 1988 beginning balance as a percent of total wages in State [2]
Alabama	$500			2.1
Alaska	64			1.2
Arizona	423			1.7
Arkansas	106			0.8
California	4,016			1.5
Colorado	98			0.4
Connecticut	263			0.7

TABLE 2.—STATE UNEMPLOYMENT TRUST FUND ACCOUNT BALANCES AT THE BEGINNING OF FISCAL YEAR 1988—Continued

[Dollars in millions]

State	1988 beginning balance	Minus loans outstanding at beginning of 1988	1988 adjusted beginning balances	Adjusted 1988 beginning balance as a percent of total wages in State [2]
Delaware	132			2.2
District of Columbia	83			0.8
Florida	1,722			2.1
Georgia	794			1.6
Hawaii	243			3.2
Idaho	114			2.2
Illinois	857	573	284	0.3
Indiana	501			1.2
Iowa	253			1.5
Kansas	365			2.2
Kentucky	238			1.1
Louisiana	15			0.1
Maine	130			1.7
Maryland	557			1.5
Massachusetts	1,090			1.7
Michigan	1,216	1,121	95	0.1
Minnesota	135			0.4
Mississippi	369			3.0
Missouri	371			1.0
Montana	41			1.0
Nebraska	85			0.9
Nevada	229			2.6
New Hampshire	160			1.8
New Jersey	1,730			2.2
New Mexico	117			1.5
New York	2,656			1.4
North Carolina	1,217			2.6
North Dakota	7			0.2
Ohio	261	199	62	0.1
Oklahoma	108			0.6
Oregon	402			2.1
Pennsylvania	650	592	58	0.1
Puerto Rico	271			3.3
Rhode Island	197			2.5
South Carolina	203			0.9

TABLE 2.—STATE UNEMPLOYMENT TRUST FUND ACCOUNT BALANCES AT THE BEGINNING OF FISCAL YEAR 1988—Continued

[Dollars in millions]

State	1988 beginning balance	Minus loans outstanding at beginning of 1988	1988 adjusted beginning balances	Adjusted 1988 beginning balance as a percent of total wages in State [2]
South Dakota	42			1.3
Tennessee	497			1.5
Texas	0	438	−438	−0.4
Utah	157			1.6
Vermont	109			2.8
Virginia	595			1.3
Virgin Islands	15			2.6
Washington	592			1.8
West Virginia	52			0.5
Wisconsin	340			0.9
Wyoming	18			0.6
Total [1]	25,406	−2,923	61	1.2

[1] Figures may not correspond exactly in U.S. Treasury data because of rounding.

[2] Total wages in the State for the 12 months ending June 30, 1986.

Source: U.S. Departments of Labor and Treasury.

The four Federal accounts in the trust fund are: (1) the Employment Security Administration Account (ESAA), which funds administration; (2) the Extended Unemployment Compensation Account (EUCA), which funds the Federal half of the extended benefits program; (3) the Federal Unemployment Account (FUA), which funds loans to insolvent State UC programs; and (4) the Federal Employee Compensation Account (FECA), which funds benefits for Federal civilian and military personnel authorized under 5 U.S.C. 85. Federal unemployment taxes finance the ESAA, EUCA, and FUA, but general revenues finance the FECA. Present law authorizes interest-bearing loans to ESAA, EUCA, and FUA from the general fund.

Table 3 summarizes the financial status of these Federal accounts at the beginning of fiscal year 1988. The FUA owed the general fund about $4.2 billion. This is a decrease of $1.7 billion or 31 percent below the prior year.

TABLE 3.—BALANCES IN THE FEDERAL ACCOUNTS OF THE UNEMPLOYMENT TRUST FUND AT THE BEGINNING OF FISCAL 1988

[In millions of dollars]

Accounts	Beginning balance	Minus general fund advances	Net beginning balance
Employment Security Administration	1,612	0	1,612
Extended unemployment compensation	1,291	0	1,291
Federal unemployment (State loans)	1,949	−4,203	−2,254
Federal employee compensation	92	0	92

Source: U.S. Department of Treasury.

BENEFITS

Coverage

In order to qualify for benefits, an unemployed person usually must have worked recently for a covered employer for a specified period of time and for a certain amount of wages. About 97 million individuals are covered by UC. This is approximately 97 percent of all wage and salary workers or about 85 percent of all employed persons.

The Federal Unemployment Tax Act (FUTA) covers certain employers that State laws also must cover for employers in the States to qualify for the 5.4 percent Federal credit. Since employers in the States would lose this credit and their employees would not be covered if the States did not have this coverage, all States cover the following groups: (1) Except for nonprofit organizations, State-local governments, certain agricultural labor, and certain domestic service, FUTA covers employers who paid wages of at least $1,500 during any calendar quarter or who employed at least one worker in at least 1 day of each of 20 weeks in the current or prior year; (2) FUTA covers agricultural labor for employers who paid cash wages of at least $20,000 for agricultural labor in any calendar quarter or who employed 10 or more workers in at least 1 day in each of 20 different weeks in the current or prior year. In addition, section 3306(c)(1) of FUTA exempts certain alien farmworkers until January 1993; and (3) FUTA covers domestic service employers who paid cash wages of $1,000 or more for domestic service during any calendar quarter in the current or prior year.

FUTA requires coverage of nonprofit organization employers of at least four workers for 1 day in each of 20 different weeks in the current or prior year and State-local governments without regard to the number of employees. Nonprofit and State-local government organizations are not, however, required to pay Federal unemployment taxes, but instead may choose to reimburse the system for benefits paid to their laid off employees.

States may cover certain employment not covered by FUTA, but most States have not expanded FUTA coverage significantly. The excluded coverage involves: (1) self-employment; (2) certain agricultural labor and domestic service; (3) service for relatives; (4) service of patients in hospitals; (5) certain student interns; (6) certain alien farmworkers; (7) certain seasonal camp workers; and (8) railroad workers.

The number of covered workers receiving unemployment compensation

Although the UC system covers about 85 percent of all employed persons, table 4 shows that on average only about 1 out of 3 unemployed persons were receiving UC benefits in 1987. This compares with a peak of 81 percent of the unemployed receiving UC benefits in April 1975 and a low point of about 26 percent in October 1987.

TABLE 4.—INSURED UNEMPLOYMENT AS A PERCENT OF TOTAL UNEMPLOYMENT

Year	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Avg.
1967.....	52	52	54	54	50	30	39	41	33	33	35	47	43
1968.....	57	50	52	50	45	26	34	38	33	34	38	48	42
1969.....	54	54	52	48	43	27	35	36	31	33	40	51	41
1970.....	57	54	52	53	53	36	42	45	42	44	48	53	48
1971.....	58	58	61	59	56	42	45	48	44	46	47	55	52
1972.....	56	58	56	52	49	36	41	38	33	34	38	47	45
1973.....	51	46	46	44	43	31	36	37	34	38	38	48	41
1974.....	53	54	57	60	55	40	43	44	40	42	48	60	50
1975.....	66	73	77	81	79	72	77	79	73	74	76	80	76
1976.....	78	75	76	73	72	58	66	66	60	59	60	63	67
1977.....	67	66	66	66	59	46	52	49	47	48	49	57	56
1978.....	54	54	50	47	44	36	39	42	35	37	34	43	43
1979.....	48	48	47	47	42	33	39	38	37	38	40	49	42
1980.....	52	51	53	52	49	45	49	49	55	49	50	54	50
1981.....	54	50	48	46	40	35	37	37	36	34	38	41	41
1982.....	47	44	48	49	45	40	42	42	43	48	49	47	45
1983.....	50	53	51	53	53	40	39	36	34	33	39	41	44
1984.....	40	38	38	36	34	30	31	31	30	31	31	38	34
1985.....	40	41	41	39	32	28	30	30	28	27	32	37	34
1986.....	38	36	37	35	32	29	32	32	29	30	32	37	33
1987.....	37	37	38	35	31	28	30	29	28	26	29	....	....

Source: USDOL/ETA/UIS, Division of Actuarial Services.

Eligibility

States have developed diverse and complex methods for determining UC eligibility. In general there are three major factors: (1) the amount of recent employment and earnings; (2) demonstrated ability and willingness to seek and accept suitable employment; and (3) certain disqualifications related to a claimant's most recent job separation or job offer refusal.

Monetary qualifications

Table 5 shows the State monetary qualification requirements in the base year for the minimum and maximum weekly benefit amounts, and for the maximum total potential benefits. The base year is a recent 1-year period that most States (41) define as the first 4 of the last 5 completed calendar quarters before the unemployed person claims benefits. Most States require employment in at least 2 calendar quarters of the base year. Qualifying wages for the minimum weekly benefit amount vary from $150 in Hawaii to $3,650 in Oklahoma. For the maximum weekly benefit amount, the range is $3,349 in Indiana to $23,500 in New Hampshire. The range of qualifying wages for the maximum total potential benefits, which is the product of the maximum weekly benefit amount and the maximum potential weeks of benefits, is $4,400 in Puerto Rico to $23,500 in New Hampshire.

TABLE 5.—MONETARY QUALIFICATION REQUIREMENTS FOR MINIMUM AND MAXIMUM WEEKLY BENEFIT AMOUNTS AND MAXIMUM TOTAL POTENTIAL BENEFITS IN 1988 [1]

State	Required total earnings in base year			Minimum work in base year (quarters) [3]
	For minimum weekly benefit	For maximum weekly benefit	For maximum potential benefits [2]	
Alabama	$774	$4,302	$9,358	2Q
Alaska	1,000	19,750	19,750	2Q
Arizona	1,500	5,044	10,528	2Q
Arkansas	1,080	10,608	15,912	2Q
California	1,200	5,533	8,630	
Colorado	1,000	22,152	22,152	
Connecticut	600	8,640	8,640	2Q
Delaware	720	15,990	15,990	
District of Columbia	900	8,625	13,000	2Q
Florida	400	8,000	20,800	2Q
Georgia	1,350	7,750	16,118	2Q
Hawaii	150	6,690	6,690	2Q
Idaho	1,430	6,110	15,886	2Q
Illinois	1,600	9,321	9,321	2Q
Indiana	2,500	3,349	9,984	2Q
Iowa	870	5,762	13,026	2Q
Kansas	1,530	6,120	15,912	2Q
Kentucky	1,500	12,700	12,700	2Q
Louisiana	300	10,225	19,739	2Q
Maine	1,865	4,164	12,558	2Q
Maryland	900	7,020	7,020	2Q
Massachusetts	1,200	7,080	19,667	
Michigan	2,010	8,815	15,427	2Q
Minnesota	1,250	8,125	19,500	2Q
Mississippi	1,200	5,200	10,140	2Q
Missouri	750	4,667	10,920	2Q
Montana	1,098	7,388	15,606	2Q
Nebraska	1,200	3,650	10,449	2Q

TABLE 5.—MONETARY QUALIFICATION REQUIREMENTS FOR MINIMUM AND MAXIMUM WEEKLY BENEFIT AMOUNTS AND MAXIMUM TOTAL POTENTIAL BENEFITS IN 1988 [1]—Continued

State	Required total earnings in base year			Minimum work in base year (quarters) [3]
	For minimum weekly benefit	For maximum weekly benefit	For maximum potential benefits [2]	
Nevada	600	6,638	13,806	2Q
New Hampshire	2,800	23,500	23,500	2Q
New Jersey	1,620	8,033	14,058	2Q
New Mexico	1,031	5,168	6,890	2Q
New York	1,600	7,180	7,180	2Q
North Carolina	1,945	10,608	15,912	2Q
North Dakota	2,795	11,635	14,893	2Q
Ohio	1,702	6,280	8,164	2Q
Oklahoma	3,640	7,387	9,100	2Q
Oregon	1,000	17,760	17,760	2Q
Pennsylvania	1,320	10,000	10,000	2Q
Puerto Rico	280	4,400	4,400	2Q
Rhode Island	1,420	7,500	15,750	2Q
South Carolina	900	5,148	10,296	2Q
South Dakota	1,568	7,840	10,917	2Q
Tennessee	1,508	9,560	15,080	2Q
Texas	1,221	7,770	20,222	2Q
Utah	1,400	7,878	19,452	2Q
Virgin Islands	1,287	5,616	11,232	2Q
Vermont	1,400	6,400	6,400	2Q
Virginia	2,900	8,350	16,700	2Q
Washington	1,325	10,250	18,450	....
West Virginia	2,200	21,250	21,250	2Q
Wisconsin	1,258	6,766	13,134	2Q
Wyoming	1,440	7,920	17,157	2Q

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[1] Based on benefits for total unemployment. Amounts payable can be stretched out over a longer period in the case of partial unemployment.

[2] Based on maximum weekly benefit amount paid for maximum number of weeks. Total potential benefits equal a worker's weekly benefit amount times this potential duration.

[3] Number of quarters of work in base year required to qualify for minimum benefits. "2Q" denotes that State directly or indirectly requires work in at least 2 quarters of the base year. States without an entry have the minimum work requirement specified as a wage amount.

Source: U.S. Department of Labor.

Since the beginning of 1987, 16 States increased and 5 decreased the required earnings in the base year to qualify for the minimum weekly benefit amount. Thirty-seven States increased the qualification requirement for the maximum weekly benefit amount. Thirty-seven States increased and 3 decreased their qualification requirements for maximum potential benefits.

Ability to work and availability for work

All State laws provide that a claimant must be: (1) able to work; and (2) available for work. A claimant must meet these conditions continually to receive benefits.

Only minor variations exist in State laws setting forth the requirements concerning "ability to work." A few States specify that a claimant must be mentally and physically able to work.

"Available for work" is often translated to mean being ready, willing, and able to work. In addition to registration for work at a local employment office, most State laws require that a claimant actively seek work or make a reasonable effort to obtain work. Generally, a person may not refuse an offer of or referral to "suitable work" without good cause.

"Suitable work" is generally work in a claimant's customary occupation, which meets certain health, safety, moral, and labor standards. Most State laws list certain criteria by which the "suitability" of a work offer is to be tested. The usual criteria include the degree of risk to a claimant's health, safety, and morals; the physical fitness and prior training, experience, and earnings of the person; the length of unemployment and prospects for securing local work in a customary occupation; and the distance of the available work from the claimant's residence. Generally, as the length of unemployment increases the claimant is required to accept a wider range of jobs.

In addition, Federal law requires States to deny benefits provided under the extended benefit program to any individual who fails to accept any work that is offered in writing or is listed with the State employment service, or fails to apply for any work to which he or she is referred by the State agency, if the work is within the person's capabilities, pays wages equal to the highest of the Federal or any State or local minimum wage, pays a gross weekly wage that exceeds the person's average weekly unemployment compensation benefits plus any supplemental unemployment compensation (usually private) payable to the individual, and is consistent with the State definition of "suitable" work in other respects.

States must refer extended benefits claimants to any job meeting these requirements. If the State, based on information provided by the individual, determines that the individual's prospects for obtaining work in his or her customary occupation within a reasonably short period are good, the determination of whether any work is "suitable work" is made in accordance with State law rather than the above.

There are certain circumstances under which Federal law provides that State and extended benefits may not be denied. A State may not deny benefits to an otherwise eligible individual for refusing to accept new work under any of the following conditions: (1) If the position offered is vacant directly due to a strike, lockout, or other labor dispute; (2) if the wages, hours, or other conditions of the work offered are substantially less favorable to the individual than in those prevailing for similar work in the locality; (3) if as a condition of being employed the individual would be required to join a company union or to resign from or refrain from joining any bona fide labor organization. Further, benefits may not be denied solely on the grounds of pregnancy. The State is prohibited from canceling wage credits or totally denying benefits except in cases of misconduct, fraud, or receipt of disqualifying income.

There are also certain conditions under which Federal law requires that benefits be denied. For example, benefits must be denied to employees of education institutions during summer (and other vacation periods) if they have a reasonable assurance of reemployment; to professional athletes between sport seasons; and to aliens not legally admitted to work in the United States.

Disqualifications

The major causes for disqualification from benefits are not being able to work or available for work, voluntary separation from work without good cause, discharge for misconduct connected with the work, refusal of suitable work without good cause, and unemployment resulting from a labor dispute. Disqualification for one of these reasons may result in a postponement of benefits for some prescribed period, a cancellation of benefit rights, or a reduction of benefits otherwise payable.

Of the 16.1 million "monetarily eligible" initial UC claims in fiscal year 1987, 22.6 percent were disqualified. This figure subdivides into 5.9 percent for not being able to work or available for work, 5.7 percent for voluntarily leaving a job without good cause, 3.6 percent for being fired for misconduct on the job, 0.2 percent for refusing suitable work, and 7.2 percent for committing other disqualifying acts. The total disqualification rate ranged from a low of 4.7 percent in Tennessee to a high of 88.3 percent in Nebraska with Colorado the next highest at 71.4 percent. (Note that a claimant can be disqualified for any week claimed so that it is possible for a claimant to be disqualified more times than the total number of his initial claims in his benefit year.)

Federal law requires that benefits provided under the extended benefits program will be denied to an individual for the entire spell of his or her unemployment if he or she was disqualified from receiving State benefits because of voluntarily leaving employment, discharge for misconduct, or refusal of suitable work. These benefits will be denied even though the disqualification was subsequently lifted with respect to the State benefits prior to reemployment. The person could receive these benefits, however, if the disqualification is lifted because he or she became reemployed and met the work or wage requirement of State law.

Ex-service members

The Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) established new requirements for the payment of benefits to ex-service members under the unemployment compensation for ex-service members (UCX) program. Under the act, benefits were limited to individuals who (1) had 365 or more days of military service; (2) were discharged or released under honorable conditions; (3) did not resign or voluntarily leave the service (i.e., they were not eligible for reenlistment); and (4) were not released or discharged "for cause" as defined by the Department of Defense. The requirements applied to individuals who left Federal military service on or after July 1, 1981, but only for weeks of unemployment that began on or after August 13, 1981, the date of enactment of Public Law 97-35.

The Miscellaneous Revenue Act of 1982 (Public Law 97-362) modified the above eligibility requirements for ex-service members. Federal unemployment benefits are now payable to unemployed ex-service members who: (1) are separated under honorable conditions (and, in the case of officers, did not resign for the good of the service); and (2) have completed the first full term of active service they agreed to serve. Ex-service members who are separated prior to completing their first full term of active service can qualify for unemployment compensation benefits if they are separated under honorable conditions: (a) for the convenience of the Government under an early release program; (b) because of medical disqualification, pregnancy, parenthood, or any service-incurred injury or disability; (c) because of hardship; or (d) if they have served for 365 continuous days, because of personality disorder or inaptitude. In addition to these eligibility requirements, ex-service members must wait 4 weeks from the date of their separation from the service before they may receive benefits. The maximum number of weeks of benefits an ex-service member may receive based on his employment in the military is 13. These eligibility provisions are effective for separations from the service on or after July 1, 1981, but only for weeks of unemployment beginning on or after October 25, 1982.

Pension offset

The Unemployment Compensation Amendments of 1976 (Public Law 94-566) required all States to reduce an individual's unemployment compensation benefits by the amount of any governmental or private pension or retirement pay received by the individual. Public Law 96-364 modified this offset requirement.

Under current law, States are required to make the offset only in those cases in which the work-related pension was maintained or contributed to by a "base period" or "chargeable" employer. Entitlement to, and the amount and duration of, unemployment benefits are based on work performed during this State-specified base period. A "chargeable" employer is one whose account will be charged for unemployment compensation received by the individual.

States are allowed to reduce the amount of the offset by an amount consistent with any contribution the employee made toward the pension. For example, this allows States to limit the offset to one-half of the amount of a social security pension received by an individual who qualifies for unemployment benefits.

Taxation of unemployment insurance benefits

The Tax Reform Act of 1986 (Public Law 99-514) made all unemployment compensation taxable after December 31, 1986. Prior law applied Federal income taxes only to unemployment compensation received by individuals with incomes above certain levels. (See table 15.)

Amount and duration of weekly benefits

In general, the States set weekly benefit amounts as a fraction of the individual's average weekly wage up to some State-determined maximum. The total maximum duration available under current law is 39 weeks. The permanent, regular State programs usually provide up to 26 weeks. (Only Puerto Rico provides fewer weeks, providing a maximum of 20 weeks of benefits.) The permanent Federal-State extended benefits program provides up to 13 additional weeks in States where unemployment rates are relatively high.

The State-determined weekly benefit amounts generally replace between 50 and 70 percent of the individual's average weekly pretax wage up to some State-determined maximum. The average weekly wage is often calculated only from the calendar quarter in the base year in which the claimant's wages were highest. The State-determined maximum weekly benefit amounts generally vary between 50 and 70 percent of the average weekly covered wage in each State. Individual wage replacement rates tend to vary inversely with the claimant's average weekly pretax wage with high wage earners receiving lower wage replacement rates. Partly as a result, the national average weekly benefit amount as a percent of the average weekly covered wage was only 36 percent in fiscal year 1986.

Table 6 shows the minimum and maximum weekly benefit amounts and potential duration for each State program. In fiscal year 1987, the national average weekly benefit amount was $139 and the average duration was 14.7 weeks, making the average total benefits $2,043. The minimum weekly benefit amounts for 1987 vary from $5 in Hawaii to $62 in Alaska. The maximum weekly benefit amounts range from $96 in Indiana to $354 in Massachusetts. Most States vary the duration of benefits with the amount of earnings the claimant has in his base year. Nine States provide the same duration, however, for all claimants. The minimum durations range from 1 week in Wisconsin to 26 weeks in 8 States. The maximum duration is 26 weeks in 50 States. Only Puerto Rico has a maximum duration of fewer than 26 weeks at 20 weeks and 2 States have maximum durations higher than 26 weeks up to 30 weeks in Massachusetts and Washington.

Since the beginning of 1986, 14 States increased their minimum weekly benefit amounts. Thirty-five States raised their maximum weekly benefit amounts. Also, one State lowered its minimum potential duration and two States increased it.

TABLE 6.—AMOUNT AND DURATION OF WEEKLY BENEFITS FOR TOTAL UNEMPLOYMENT UNDER THE REGULAR STATE PROGRAMS

State	1988 weekly benefit amount [1]		1987 average weekly benefit	1988 potential duration (weeks)		1987 average duration (weeks)
	Minimum	Maximum		Minimum	Maximum	
Alabama	$22	$120	$101	11	26	12
Alaska	38–62	188–260	159	16	26	17
Arizona	40	135	119	12	26	14
Arkansas	36	204	123	10	26	13
California	30	166	121	12	26	16
Colorado	25	213	160	8	26	14
Connecticut	15–22	216–266	164	26	26	11
Delaware	20	205	138	18	26	11
District of Columbia	26	250	175	17	26	19
Florida	10	200	127	10	26	14
Georgia	37	155	118	10	26	10
Hawaii	5	223	151	26	26	13
Idaho	44	188	134	10	26	13
Illinois	51	176–230	146	26	26	18
Indiana	40	96–161	105	9	26	13
Iowa	25–30	167–205	142	11	26	15
Kansas	51	204	158	10	26	15
Kentucky	22	151	107	15	26	14
Louisiana	10	191	145	12	26	19
Maine	26–39	161–241	129	11	26	11
Maryland	25–31	195	148	26	26	14
Massachusetts	14–21	236–354	170	10	30	14
Michigan	54	242	164	15	26	13
Minnesota	38	250	175	10	26	15
Mississippi	30	130	100	13	26	14
Missouri	22	140	113	11	26	14
Montana	45	181	131	8	26	14
Nebraska	20	134	111	20	26	12
Nevada	16	177	139	12	26	14
New Hampshire	39	156	122	26	26	6
New Jersey	48	241	165	15	26	15
New Mexico	31	159	122	19	26	18
New York	40	180	139	26	26	17
North Carolina	16	204	124	13	26	10
North Dakota	43	179	147	12	26	15
Ohio	42	157–248	149	20	26	15
Oklahoma	16	197	141	20	26	16
Oregon	52	222	143	6	26	15
Pennsylvania	35–40	252–260	159	16	26	16
Puerto Rico	7	110	73	20	20	19
Rhode Island	43–53	225–281	138	12	26	12

TABLE 6.—AMOUNT AND DURATION OF WEEKLY BENEFITS FOR TOTAL UNEMPLOYMENT UNDER THE REGULAR STATE PROGRAMS—Continued

State	1988 weekly benefit amount [1]		1987 average weekly benefit	1988 potential duration (weeks)		1987 average duration (weeks)
	Minimum	Maximum		Minimum	Maximum	
South Carolina	20	132	103	15	26	11
South Dakota	28	140	110	18	26	12
Tennessee	30	145	96	12	26	12
Texas	34	210	162	13	26	17
Utah	13	202	159	10	26	14
Vermont	17	160	127	26	26	13
Virginia	58	167	133	12	26	9
Virgin Islands	30	144	107	14	26	15
Washington	55	205	150	16	30	15
West Virginia	24	225	147	26	26	14
Wisconsin	38	200	143	1	26	14
Wyoming	36	198	166	12	26	20

[1] A range of amounts is shown for those States that provide dependents allowances.

NA: Not available.

Source: U.S. Department of Labor.

EXTENDED BENEFITS

The extended benefits program provides one-half of a claimant's total State benefits up to 13 weeks in States with an activated program for a combined maximum of 39 weeks of regular and extended benefits. Weekly benefit amounts are identical to the State benefits for each claimant. The program activates in a State under two conditions: (1) if the State's 13-week average insured unemployment rate (IUR) in the most recent 13 weeks is at least 120 percent of the average of its 13-week IUR's in the last 2 years for the same 13-week calendar period and its current 13-week average IUR is at least 5.0 percent; or (2) at State option, if its current 13-week average IUR is at least 6.0 percent. Only 13 State programs have not adopted the second, optional condition. The 13-week average IUR is calculated from the ratio of the average number of insured unemployed persons under the regular State programs in the last 13 weeks to the average covered employment in the first 4 of the last 6 completed calendar quarters. Table 7 shows the 13-week IUR's by State for the first week in January 1983, 1984, 1985, 1986, 1987, and 1988. As indicated in the last column, no State had an activated EB program in the first week of January 1988.

TABLE 7.—STATE EXTENDED BENEFIT INDICATORS FOR THE FIRST WEEK IN JANUARY 1983 THROUGH 1988 AND EB BENEFIT WEEKS FOR JANUARY 1988

	13-week insured unemployment rate						1988 as percent of prior 2 years	EB weeks
	1983	1984	1985	1986	1987	1988		
Alabama	6.00	3.79	3.69	3.16	3.25	2.23	69	0
Alaska	6.89	6.10	6.18	6.81	7.45	5.89	82	0
Arizona	4.36	2.19	1.54	1.61	1.86	1.59	91	0
Arkansas	6.08	3.75	3.93	3.82	3.99	3.29	84	0
California	5.32	3.86	3.36	3.49	3.25	2.61	77	0
Colorado	3.45	2.60	1.91	2.12	2.52	1.98	84	0
Connecticut	3.42	2.06	1.54	1.61	1.40	1.04	69	0
Delaware	3.17	2.01	1.49	1.26	1.20	0.76	70	0
Dist. of Columbia	3.82	2.55	2.09	1.99	1.97	1.68	84	0
Florida	2.58	1.48	1.32	1.35	1.23	1.00	77	0
Georgia	3.46	1.91	1.84	1.65	1.71	1.27	75	0
Hawaii	3.58	3.13	3.26	2.21	1.86	1.54	75	0
Idaho	6.81	4.64	3.92	4.27	4.33	3.33	77	0
Illinois	5.84	3.61	2.94	2.94	2.66	2.15	76	0
Indiana	5.18	2.63	2.46	2.08	2.06	1.36	65	0
Iowa	4.25	2.63	2.74	2.91	2.82	1.69	58	0
Kansas	4.26	2.47	2.21	2.49	2.51	2.00	80	0
Kentucky	5.92	3.59	3.12	3.19	2.68	2.02	68	0
Louisiana	5.36	4.22	3.89	4.42	5.32	3.13	64	0
Maine	4.42	3.78	3.41	2.95	2.20	1.67	64	0
Maryland	4.26	2.69	2.10	2.09	1.76	1.40	72	0
Massachusetts	3.93	2.48	2.14	2.28	1.95	1.55	73	0
Michigan	7.43	3.39	3.37	2.90	3.12	3.17	106	0
Minnesota	4.05	2.56	2.29	2.61	2.21	1.87	77	0
Mississippi	6.19	3.63	3.69	3.27	3.85	2.48	69	0
Missouri	4.32	2.84	2.36	2.33	2.49	2.07	82	0
Montana	4.89	4.26	3.86	3.73	3.44	2.79	79	0
Nebraska	1.77	2.20	1.84	2.39	1.90	1.37	63	0
Nevada	4.92	3.27	2.81	2.88	2.56	2.08	72	0
New Hampshire	2.87	1.45	1.06	0.86	0.71	0.42	53	0
New Jersey	4.24	3.11	2.79	2.53	2.09	1.74	72	0
New Mexico	4.07	3.22	2.75	2.64	3.31	2.30	77	0
New York	3.85	3.08	2.70	2.52	2.28	1.92	80	0
North Carolina	4.58	2.21	2.48	2.02	1.74	1.20	63	0
North Dakota	3.20	2.67	2.65	2.84	2.70	2.15	77	0
Ohio	6.06	3.21	3.06	2.95	2.65	2.11	75	0
Oklahoma	4.06	2.09	2.14	2.36	2.90	1.87	71	0
Oregon	6.63	4.81	4.31	4.51	3.97	3.17	74	0
Pennsylvania	7.30	4.73	4.04	3.80	3.29	2.38	67	0
Puerto Rico	8.96	6.63	6.53	6.69	5.46	4.64	76	0

TABLE 7.—STATE EXTENDED BENEFIT INDICATORS FOR THE FIRST WEEK IN JANUARY 1983 THROUGH 1988 AND EB BENEFIT WEEKS FOR JANUARY 1988—Continued

	13-week insured unemployment rate						1988 as percent of prior 2 years	EB weeks
	1983	1984	1985	1986	1987	1988		
Rhode Island	5.24	3.53	3.17	2.99	2.55	2.04	73	0
South Carolina	5.63	2.58	2.98	2.59	2.10	1.50	63	0
South Dakota	2.08	1.10	1.23	1.54	1.18	1.20	88	0
Tennessee	4.53	2.79	2.76	2.61	2.34	1.95	78	0
Texas	2.85	1.88	1.50	1.72	2.78	1.91	84	0
Utah	4.83	2.75	2.54	2.27	2.39	1.62	69	0
Vermont	4.99	3.38	2.86	2.66	2.05	1.40	63	0
Virgin Islands	4.18	1.23	1.26	2.70	1.50	0.78	78	0
Virginia	2.30	3.67	3.71	1.06	0.94	0.75	35	0
Washington	6.60	5.03	4.41	4.30	3.92	3.45	83	0
West Virginia	8.59	5.55	5.66	4.19	3.79	2.78	69	0
Wisconsin	5.74	3.93	3.34	3.34	2.91	2.24	71	0
Wyoming	4.54	3.10	1.68	2.48	3.98	2.28	71	0

NA—Not available.

Source: U.S. Department of Labor.

Hypothetical Weekly Benefit Amounts for Various Workers in the Regular State Programs

The following table (table 8) illustrates the amount of benefits various full-year workers can receive in regular State programs. All of the benefit amounts are for January 1988. The first column A of the table is for a full-time worker earning the minimum wage; the second column B is for a worker earning $6 per hour, while the third column C shows benefit amounts for a worker earning $9 per hour. The final column D is a part-time worker earning the minimum wage and working 20 hours per week. The weekly benefit amount for the minimum wage worker varies from $65 to $139. The maximum amount a worker can receive in these examples (column C) in each State varies considerably, from $110 to $241 per week.

TABLE 8.—WEEKLY BENEFIT AMOUNT FOR VARIOUS FULL-YEAR WORKERS IN SELECTED STATES IN JANUARY 1988

	A	B	C	D
Alabama	73	120	120	36
Arkansas	67	120	180	33
Alaska	84	128	226	56
Arizona	70	125	125	0
California	68	105	142	38
Colorado	80	143	180	40
Connecticut	77	130	210	44
Delaware	67	120	180	33
District of Columbia	76	136	204	38
Florida	67	120	180	33
Georgia	69	124	155	34
Hawaii	70	125	188	35
Idaho	67	120	180	0
Illinois	72	133	230	56
Indiana	75	113	147	0
Iowa	79	142	205	40
Kansas	74	132	198	51
Kentucky	83	140	151	41
Louisiana	139	125	191	35
Maine	84	146	176	44
Maryland	73	130	195	37
Massachusetts	67	120	230	34
Michigan	NA	NA	NA	NA
Minnesota	67	120	180	0
Mississippi	67	120	130	33
Missouri	78	130	140	39
Montana	65	117	176	45
Nebraska	72	126	126	38
Nevada	69	124	177	34
New Hampshire	83	117	141	46
New Jersey	85	154	241	0
New Mexico	67	120	159	34
New York	67	120	180	0
North Carolina	67	120	180	33
North Dakota	67	120	179	0
Ohio	67	120	180	0
Oklahoma	69	124	187	34
Oregon	87	156	222	50
Pennsylvania	77	132	197	43
Puerto Rico	67	110	110	34
Rhode Island	80	144	236	0
South Carolina	67	120	132	33
South Dakota	67	120	140	33
Tennessee	112	145	145	67

TABLE 8.—WEEKLY BENEFIT AMOUNT FOR VARIOUS FULL-YEAR WORKERS IN SELECTED STATES IN JANUARY 1988—Continued

	A	B	C	D
Texas	70	125	188	35
Utah	68	121	182	34
Virgin Islands	70	125	144	35
Vermont	77	138	160	34
Virginia	69	124	167	0
Washington	139	205	205	69
West Virginia	73	131	198	36
Wisconsin	67	120	180	0
Wyoming	70	125	188	0

A. $3.35/hr. wage; 40 hrs./wk.; 52 wks./yr.; nonworking spouse; no children.
B. $6.00/hr. wage; 40 hrs./wk.; 52 wks./yr.; nonworking spouse; no children.
C. $9.00/hr. wage; 40 hrs./wk.; 52 wks./yr.; nonworking spouse; 2 children.
D. $3.35/hr. wage; 20 hrs./wk.; 52 wks./yr.; nonworking spouse; no children.

NA means not available.

Source: U.S. Department of Labor.

FINANCING

The Federal unemployment tax

Total unemployment taxes on employers for a full-time, full-year worker earning at least $7,000 in 1987 is estimated to have averaged about $231 or 11 cents per hour. The Federal portion is $56 or 3 cents per hour and the average State portion is about $175 or 8 cents per hour. Employer taxes will vary substantially, however, depending on the State taxable wage base, State tax rates, and reduced Federal credits.

The Federal Unemployment Tax Act (FUTA) currently imposes a minimum, net Federal payroll tax on employers of 0.8 percent on the first $7,000 paid annually to each employee. The gross FUTA tax rate is 6.2 percent, but employers in States meeting certain Federal requirements and having no delinquent Federal loans are eligible for a 5.4 percent credit, making the minimum, net Federal tax rate 0.8 percent.

Employers in States with delinquent Federal loans may face increases in their FUTA tax rate stemming from automatic reductions in the FUTA credit. States with outstanding loans from the Federal Government must repay them fully by November 10 of the calendar year in which the second consecutive January first passes with the State still having an outstanding loan. This means that a State may have from about 22 to 34 months to repay the loan without penalty, depending on when it obtained the outstanding loan. If it does not repay fully by the appropriate November 10, it becomes subject to an annual credit reduction beginning with the preceding January 1 until the State repays the loan fully. Employers must pay the additional taxes resulting from the credit reduction no later than January 31 of the next calendar year.

The credit reduction is at least 0.3 percent per year beginning with the calendar year in which the second consecutive January first passes during which the loan is outstanding. There are two potential additional credit reductions during the ensuing calendar years in which a State has an outstanding advance: (1) in the calendar years after which the third and fourth consecutive January firsts pass, the employers in the State face a reduction by the amount (adjusted for the State's taxable wage base and average wage) by which 2.7 percent exceeds the State's average tax rate on taxable wages in the calendar year to which the reduction applies; (2) in the calendar years in which the fifth through ninth consecutive January firsts pass, the employers face a reduction equal to the higher of the amount in (1) or the amount that the State's 5-year benefit cost rate exceeds the State's average tax rate on taxable wages in the calendar year to which the reduction applies. The 5-year benefit-cost rate is one-fifth of the UC benefits paid in the first 5 of the last 6 completed calendar years preceding the calendar year to which the credit reduction applies divided by taxable wages in the last calendar year.

The Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) modified FUTA provisions regarding Federal unemployment loans to the States. States are now charged interest on new loans that are not repaid by the end of the fiscal year in which they are obtained. Under previous law, States could receive these loans interest-free. The interest rate is the same rate as that paid by the Federal Government on State reserves in the Federal Unemployment Trust Fund for the quarter ending December 31 of the preceding year, but not higher than 10 percent per annum. States may not pay the interest directly or indirectly from funds in their State accounts in the Federal Unemployment Trust Fund.

Employers in Pennsylvania were subjected to a reduction in the FUTA offset credit of 1.5 percentage points for taxable year 1987.

The Omnibus Budget Reconciliation Act of 1981 added a new subsection (f) to section 3302 of FUTA, which under certain conditions fully limits the FUTA tax credit reduction to an amount that does not exceed the greater of 0.6 percent of wages subject to FUTA or the percentage reduction that was in effect for the preceding taxable year.

To qualify for a full cap in taxable year 1986, a State must have taken no action in the 12 months ending September 30, 1986, unless required under State law in effect before August 13, 1981, which has resulted or will result in:

(1) A reduction in the State's unemployment tax effort;

(2) A net decrease in the solvency of the State unemployment compensation system;

and, further, that:

(3) The State unemployment tax rate for the calendar year equals or exceeds the average benefit-cost ratio for calendar years in the five-calendar-year period ending with calendar year 1985; and

(4) The outstanding balance of advances to the State on September 30 of calendar year 1986 was not greater than the outstanding balance for such State on September 30, 1983.

Under these criteria, Michigan qualified for the full cap.

Section 272 of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) amended Section 3302 of the Internal Revenue Code of 1954 by adding subsection (g) which gives a State the option of repaying on or before November 9 a portion of its outstanding loans each year through transfer of a specified amount from its account in the Unemployment Trust Fund (UTF) to the Federal Unemployment Account (FUA) in the UTF. The transfer to FUA would be in lieu of a reduced credit in the Federal tax paid by the employers in the State. The State must meet the following criteria in order to avoid the offset credit reduction:

(1) repay all loans for the one-year period ending on November 9, plus the additional tax due by reason of the reduced credit applicable to tax year 1986;

(2) have or will have sufficient funds remaining after the transfer to pay benefits for at least three months from November 1 of the same year without receiving another title XII advance; and

(3) have taken action by amendment of the State law, after the date of the first advance taken into account, to increase the net solvency of its UI system, and such net increase equals or exceeds the potential additional taxes for such taxable year.

Under these criteria, Michigan qualified and thus, was not subject to a reduced FUTA credit for 1987.

As of November 30, 1987, outstanding unemployment loans totaled about $2.0 billion. Table 9 shows the loans made to each State. Interest-free loans in 2 States were $1.5 billion and the one interest-bearing loan to Texas was $437 million.

TABLE 9.—LOANS TO STATES FROM THE FEDERAL UNEMPLOYMENT ACCOUNT (FUA), AS OF NOVEMBER 30, 1987

[In millions of dollars, calendar year]

	Date of first loan	Interest free loans	Interest bearing loans	Total title XII loans
Michigan	April 1975	953		953
Pennsylvania	October 1975	589		589
Texas	November 1982		437	437
Total		1,542	437	1,979

Note.—Total does not include unpaid interest.

Source: U.S. Department of Labor, Unemployment Insurance Service, Division of State Program Management, Tax Administration Group.

The State unemployment taxes

The States finance their programs and half of the Extended Benefits program with employer payroll taxes imposed on at least the first $7,000 paid annually to each employee.[1] States generally adopt a taxable wage base at least as high as the Federal level because they would otherwise lose the 5.4 percent credit on the difference between the Federal taxable wage base and State taxable wage base. Table 10 shows that as of January 1987, 36 States had taxable wage bases higher than the Federal taxable wage base, ranging up to $21,100 in Alaska.

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[1] Alabama, Alaska, New Jersey, and Pennsylvania also tax employees.

Although the standard State tax rate is 5.4 percent, State tax rates based on unemployment experience can range from zero on some employers in 13 States up to a maximum as high as 10.5 percent in South Dakota.

Estimated national average State tax rates on taxable wages and total wages for 1987 were 2.5 and 1.0 percent, respectively. Estimated average State tax rates on taxable wages ranged from 0.9 percent in North Carolina to 5.4 percent in Puerto Rico. Estimated average State tax rates on total wages varied from 0.4 percent in Florida and Virginia to 2.4 percent in Alaska and Puerto Rico.

TABLE 10.—STATE UNEMPLOYMENT TAX BASES AND RATES

State	1988 tax base	1988 experience rates[1]		Estimated 1987 average tax rates as a percent of—		1987 Federal credit (percent)
		Minimum	Maximum	Taxable wages	All wages	
U.S. average	(2)	NA	NA	2.5	1.0	NA
Alabama	$8,000	0.5	5.4	1.7	0.8	(4)
Alaska	21,100	1.0	6.5	3.5	2.4	(4)
Arizona	(2)	0.1	5.4	1.4	0.5	(4)
Arkansas	7,500	0	6.0	2.8	1.2	(4)
California	(2)	0.3	5.4	2.5	0.9	(4)
Colorado	10,000	0	5.4	2.2	0.9	(4)
Connecticut	7,100	0.5	6.4	2.0	0.7	(4)
Delaware	8,500	0.1	8.0	3.0	1.1	(4)
District of Columbia	8,000	0.8	5.4	2.1	0.7	(4)
Florida	(2)	0.1	5.4	1.0	0.4	(4)
Georgia	7,500	0.01	8.64	1.6	0.6	(4)
Hawaii	8,700	0	5.4	1.7	1.2	(4)
Idaho	16,200	0.1	6.8	3.0	2.1	(4)
Illinois	9,000	0.2	6.7	4.0	1.5	(4)
Indiana	(2)	0.02	5.4	1.5	0.6	(4)
Iowa	11,000	0	9.0	2.9	1.6	(4)
Kansas	8,000	.025	5.4	2.5	1.1	(4)
Kentucky	8,000	0.3	10.0	2.8	1.0	(4)
Louisiana	8,500	0.3	6.0	4.2	1.7	(4)
Maine	(2)	0.5	6.5	2.5	1.1	(4)
Maryland	(2)	0.1	6.0	1.7	0.5	(4)
Massachusetts	(2)	1.2	7.2	2.0	0.8	(4)

TABLE 10.—STATE UNEMPLOYMENT TAX BASES AND RATES—Continued

State	1988 tax base	1988 experience rates[1]		Estimated 1987 average tax rates as a percent of—		1987 Federal credit (percent)
		Minimum	Maximum	Taxable wages	All wages	
Michigan	9,500	0	10.0	5.2	2.0	(4)
Minnesota	11,700	0.1	8.0	2.5	1.2	(4)
Mississippi	(2)	0.1	6.4	1.5	0.6	(4)
Missouri	7,000	0	7.8	1.6	0.6	(4)
Montana	12,600	0	6.4	2.0	1.4	(4)
Nebraska	(2)	0.1	5.4	1.7	0.7	(4)
Nevada	12,100	0.3	5.4	1.6	0.9	(4)
New Hampshire	(2)	0.01	6.5	0.8	0.3	(4)
New Jersey	12,000	0.3	7.0	2.5	1.4	(4)
New Mexico	10,800	0.1	5.4	2.0	1.0	(4)
New York	(2)	0	6.4	3.1	0.9	(4)
North Carolina	10,100	0.1	5.7	0.9	0.5	(4)
North Dakota	11,000	0.1	5.4	4.0	2.3	(4)
Ohio	8,000	0	5.4	3.5	1.3	(4)
Oklahoma	9,100	0.1	6.2	2.6	1.1	(4)
Oregon	14,000	0.9	5.4	3.1	1.9	(4)
Pennsylvania	8,000	0.3	9.2	4.4	1.7	3.9
Puerto Rico	(2)	(3)	(3)	5.4	2.4	(4)
Rhode Island	12,000	0.8	8.4	3.8	2.1	(4)
South Carolina	(2)	0.19	5.4	2.0	0.9	(4)
South Dakota	(2)	0.05	10.5	1.4	0.7	(4)
Tennessee	(2)	0.15	10.0	1.4	0.6	(4)
Texas	8,000	0	6.0	2.4	0.9	(4)
Utah	13,200	2.25	8.0	1.7	1.0	(4)
Vermont	8,000	0.4	8.4	4.1	1.8	(4)
Virginia	(2)	0.0	6.2	1.1	0.4	(4)
Virgin Islands	NA	0.1	9.0	3.1	2.4	(4)
Washington	15,100	0.48	5.4	4.0	2.3	(4)
West Virginia	8,000	0	7.5	4.5	1.9	(4)
Wisconsin	10,500	0.27	8.9	4.1	2.0	(4)
Wyoming	10,200	0	8.5	3.2	1.6	(4)

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[1] Actual rates could be higher if State has an additional tax.

[2] The 1988 tax base is $7,000 except as otherwise shown in this column.

[3] Puerto Rico is not experience rated. The rate in Puerto Rico is 5.4% of $7,000.

[4] All figures are 5.4 percent except as otherwise shown in this column. To the extent that this credit is lower than 5.4 percent, these additional taxes were due January 31, 1987.

NA means not available.

Note.—This table shows the State unemployment tax levels. It does not include the Federal unemployment taxes.

Source: Department of Labor (based on estimates by State agencies).

Table 11 shows recent data on unemployment compensation covered employment, wages, taxable wages, the ratio of taxable to total wages, and average weekly wages. The ratio of taxable wages to total wages in the States varied from 0.25 in New York to 0.67 in Montana.

TABLE 11.—12-MONTH AVERAGE EMPLOYMENT AND WAGES COVERED BY UNEMPLOYMENT INSURANCE (UI) FOR PERIOD ENDING JUNE 1987

State	Average employment (thousands)	Total wages (millions)	Taxable wages (millions)	Ratio of taxable wages to total wages	Average weekly wages
United States	97,293	$1,951,715	$654,908	0.34	$386
Alabama	1,383	24,125	9,088	0.38	336
Alaska	191	5,380	2,591	0.48	541
Arizona	1,320	25,058	8,307	0.33	365
Arkansas	783	12,593	4,954	0.39	309
California	11,605	259,490	74,519	0.29	430
Colorado	1,340	27,352	9,695	0.35	393
Connecticut	1,589	36,884	10,278	0.28	446
Delaware	302	6,041	2,038	0.34	385
District of Columbia	415	10,553	2,747	0.26	488
Florida	4,628	82,850	29,566	0.36	344
Georgia	2,587	48,975	17,202	0.35	364
Hawaii	423	7,549	4,187	0.55	343
Idaho	314	5,160	2,850	0.55	317
Illinois	4,683	101,261	32,697	0.32	416
Indiana	2,154	40,907	12,837	0.31	365
Iowa	1,025	17,111	7,900	0.46	321
Kansas	940	16,895	7,513	0.44	346
Kentucky	1,204	20,986	7,597	0.36	335
Louisiana	1,405	25,539	7,928	0.31	350
Maine	463	7,653	2,754	0.36	318
Maryland	1,821	36,459	11,015	0.30	385
Massachusetts	2,895	62,334	20,135	0.32	414
Michigan	3,511	79,834	26,327	0.33	437
Minnesota	1,836	36,442	14,002	0.38	382
Mississippi	802	12,266	4,655	0.38	294
Missouri	2,048	38,911	12,778	0.33	366
Montana	250	3,952	2,660	0.67	304
Nebraska	619	9,950	3,235	0.33	309
Nevada	469	8,873	4,557	0.51	364
New Hampshire	484	8,911	3,108	0.35	354

TABLE 11.—12-MONTH AVERAGE EMPLOYMENT AND WAGES COVERED BY UNEMPLOYMENT INSURANCE (UI) FOR PERIOD ENDING JUNE 1987—Continued

State	Average employment (thousands)	Total wages (millions)	Taxable wages (millions)	Ratio of taxable wages to total wages	Average weekly wages
New Jersey	3,388	77,349	30,186	0.39	439
New Mexico	474	8,057	3,422	0.42	327
New York	7,716	183,661	45,855	0.25	458
North Carolina	2,712	46,648	20,376	0.44	331
North Dakota	221	3,463	1,409	0.41	302
Ohio	4,308	86,226	27,682	0.32	385
Oklahoma	1,032	18,625	7,256	0.39	347
Oregon	1,020	18,698	9,313	0.50	353
Pennsylvania	4,585	89,843	28,953	0.32	377
Puerto Rico	737	8,230	3,336	0.41	215
Rhode Island	433	7,764	3,426	0.44	345
South Carolina	1,287	21,370	7,653	0.36	319
South Dakota	229	3,277	1,156	0.35	275
Tennessee	1,871	33,121	11,496	0.35	341
Texas	6,193	123,184	38,760	0.31	383
Utah	567	9,935	4,593	0.46	337
Vermont	228	3,872	1,461	0.38	327
Virginia	2,392	44,971	14,889	0.33	362
Virgin Islands	38	580	286	0.49	292
Washington	1,689	33,222	14,631	0.44	378
West Virginia	555	10,178	3,359	0.33	353
Wisconsin	1,958	35,956	14,521	0.40	353
Wyoming	173	3,195	1,173	0.37	356

ADMINISTRATION'S FISCAL YEAR 1989 FINANCIAL PROJECTIONS

Federal loans to State unemployment compensation programs

In its fiscal year 1989 budget, the administration projected total outstanding loans to State UC programs at $1.8 and $1.6 billion at the end of fiscal years 1988 and 1989, respectively. It also projected new loans in these years at $0.7 and $0.6 billion, respectively. Table 12 provides a breakdown of the projected new Federal loans and the loan balances in the States obtaining new loans for fiscal years 1988 and 1989.

TABLE 12.—PROJECTED NEW FEDERAL LOANS TO STATE UNEMPLOYMENT COMPENSATION PROGRAMS IN FISCAL YEARS 1988 AND 1989

[In millions of dollars]

State	Outstanding loans (as of Nov. 30, 1987)	Fiscal year 1988		Fiscal year 1989	
		Loans	Balance	Loans	Balance
Alaska	0	0	0	20	10
Michigan	953	0	950	0	780
Pennsylvania	589	0	180	0	0
Texas	437	700	670	500	740
Wyoming	0	4	2	50	25
Total	1,979	704	1,802	570	1,555

Note.—State projections have more variability than U.S. total projections and should be used with caution. Balance is for the end of the fiscal year.

Source: U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance Service, Division of Actuarial Services. Based on administration's fiscal year 1988 budget.

Interest charges

Table 13 classifies the projected interest charges on Federal loans to insolvent State UC programs at the end of fiscal years 1988 and 1989. The total projected charges are $0.05 and $0.06 billion in fiscal years 1988 and 1989, respectively.

TABLE 13.—PROJECTED INTEREST CHARGES ON FEDERAL LOANS TO INSOLVENT STATE UNEMPLOYMENT COMPENSATION PROGRAMS IN FISCAL YEARS 1988 AND 1989

Interest charges (in millions of dollars)	States	
	Fiscal year 1988	Fiscal year 1989
1–10		Alaska Wyoming
11–50	Texas	
51–100		Texas

Source: U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance Service, Division of Actuarial Services. Based on administration's fiscal year 1988 budget.

Projected Federal unemployment tax credit reductions

Pennsylvania is the only State still subject to a credit reduction of 1.5 percentage points. Employers in Pennsylvania are projected to pay $411 million of additional Federal unemployment taxes resulting from the projected credit reduction in 1987.

ADMINISTRATIVE FINANCING AND ALLOCATION

State unemployment insurance administrative expenses are Federally financed. A portion of revenue from the Federal unemployment tax (FUTA) is designated for administration and to maintain a system of public employment offices.

FUTA revenue flows into three Federal accounts in the Unemployment Trust Fund: (1) the Employment Security Administration Account (ESAA), (2) the Extended Unemployment Compensation Account (EUCA), and (3) the Federal Unemployment Account (FUA). Authorized by title IX of the Social Security Act, ESAA finances administrative costs associated with Federal and State unemployment compensation and employment services.

Under current law, 67.5 percent of FUTA revenue is allocated to ESAA. Funds authorized for administration are limited to 95 percent of the estimated annual revenue that is expected to flow to ESAA from the Federal unemployment tax. The amount is estimated after transfer of 10 percent of FUTA receipts earmarked for the extended unemployment compensation account and the Federal unemployment account. Funds for administration may be augmented by three-eighths of the amount in ESAA at the beginning of the fiscal year, or $150 million, whichever is less, if the rate of insured unemployment is at least 15 percent higher than it was over the corresponding calendar quarter in the immediately preceding year.

Title III of the Social Security Act authorizes payment to each State, with an approved unemployment insurance law, such amounts as are deemed necessary for the proper and efficient administration of such law during the fiscal year. Allocations are based on (1) the population of the State, (2) an estimate of the number of persons covered by the State unemployment insurance law, (3) an estimate of the cost of proper and efficient administration of such law; and (4) such other factors as the Secretary of Labor finds relevant.

Subject to the limit of available resources, the allocation of State grants for administration is the summation of resources derived in two major areas, the Unemployment Insurance Service (UI) and the Employment Service (ES). Each area has its own allocation methodology subject to general constraints set forth in the Social Security Act and the Wagner-Peyser Act.

Each year, as part of the development of the President's Budget, the Department of Labor in conjunction with the Department of Treasury, estimates revenue expected from FUTA and the appropriate amount which will be available for administration (and the Federal share of extended benefits). The estimate of FUTA revenues is based on several factors: (1) a wage base of $7,000 per employee, (2) a tax rate of 0.8 percent (0.54 percentage point for administration, 0.16 percentage point for extended benefits, and 0.1 percentage point for the Federal loan account), (3) the administration's projection of the level of unemployment and the growth in wages, and (4) the level of covered employment subject to FUTA. Additionally, a determination is made based on the administration's forecast for unemployment as to whether the rate will increase by at least 15 percent.

Each year the President's Budget sets forth an estimate of national unemployment in terms of the volume of unemployment claims per week. This is characterized as average weekly insured unemployment (AWIU). A portion of AWIU is expressed as "base" and the remainder as "contingency." At the present time, the base is set at the level of resources required to process an average weekly volume of 2.0 million weeks of unemployment.

Resources available to each State to administer its unemployment compensation program (i.e., process claims and pay benefits) are provided from either "base" funds or "contingency" funds. At the beginning of the fiscal year, only the base funds are allocated while contingency funds are allocated on a needs basis as workload materializes. Base funds are distributed to the State for use throughout the fiscal year and are available regardless of the level of unemployment (workload) realized. If a State processes workloads in excess of the base level they receive the contingency funds determined by the extent of the resources required to process the additional workload.

The allocation of the base UI grant funds to each State is made by:

(1) Projecting the workloads that each State is expected to process.

These projections are then adjusted so that the sum across States for each workload item is equal to the budgeted base workload.

(2) Determining the staff required to process each State's projected workload.

The staff requirements are computed by multiplying the projected workloads by minutes per unit (MPU) and dividing the result by the number of work minutes per staff year for each State. The MPUs are derived from work measurement studies conducted in each State that establish the number of minutes required to perform specific tasks. The MPUs developed from the studies are necessarily reduced so that the total of computed staff years for each workload item across States equals the staff years available in the appropriation. The MPUs are reduced according to a complex mathematical formula that takes into account workload volume and the range of MPUs.

(3) Multiplying of the final staff-year allocations for each State by the cost per staff year (i.e., State salary level) to determine dollar funding levels.

(4) Overhead resources (administrative and management staff and nonpersonal services) are allocated using a methodology driven by the program staff years developed in the UI base allocation. In summary, the administrative staff allocation is calculated by multiplying program staff times a State's administrative staff historical rate. The administrative staff calculated are then multiplied by the States cost per staff year to determine the allocation. Nonpersonal services are calculated using an historical staff year unit cost increased annually for inflation provided in the budget. The revised unit cost is multiplied by staff years to determine the allocation.

Each Department of Labor regional office may redistribute resources among the States in its area with national office approval.

RECENT MAJOR LEGISLATION

Major Federal laws passed by recent sessions of Congress and some of their provisions are:

(1) The Employment Security Amendments of 1970 (Public Law 91-373) expanded FUTA coverage primarily to small businesses,

nonprofit organizations, and higher educational institutions. It also raised the taxable wage base from the original $3,000 to $4,200 in 1972; increased the minimum, net Federal unemployent tax rate from 0.4 to 0.5 percent in 1970; and created the Federal-State extended benefits program.

(2) The Unemployment Compensation Amendments of 1976 (Public Law 94-566), extended FUTA coverage primarily to State-local government workers and certain agricultural and domestic labor. It also raised the taxable wage base to $6,000 in 1978 and temporarily increased the minimum, net Federal unemployment tax rate from 0.5 to 0.7 percent in 1977.

(3) The Omnibus Budget Reconciliation Act of 1980 (Public Law 96-499) added among other provisions a denial of extended benefits to claimants under certain circumstances who have rejected a minimum wage job.

(4) The Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) imposed interest charges up to 10 percent per annum under certain conditions on loans obtained by State UC programs after April 1, 1982. It also cut an estimated $3 to $4 billion from the Extended Benefits program in fiscal year 1983.

(5) The Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248) increased the taxable wage base from $6,000 to $7,000 and raised the minimum, net Federal unemployment tax rate to 0.8 percent in 1983. It also raised the gross tax and credit rates in 1985 to 6.2 and 5.4 percent, respectively. This leaves the minimum, net Federal rate unaffected, but raises the maximum, potential, net tax rate in States with delinquent loans from 3.4 to 6.2 percent. The Act also created the temporary Federal supplemental compensation program, which authorized 6 to 10 additional weeks of benefits through March 31, 1983.

(6) The Surface Transportation Assistance Act (Public Law 97-424), passed in the lame-duck session of Congress, added 2 to 6 weeks to the Federal Supplemental Compensation program for a combined maximum in that program of 8 to 16 weeks.

(7) The Social Security Amendments of 1983 (Public Law 98-21) extended the Federal supplemental compensation program through September 30, 1983, providing a maximum of 8 to 14 weeks of benefits. It also established conditions under which States could defer the payment of interest on loans from the Federal Unemployment Account and qualify for reduced FUTA credit reductions.

(8) The Federal Supplemental Compensation Amendments of 1983 (Public Law 98-135) extended the Federal Supplemental Compensation program through March 31, 1985, providing a maximum of 8 to 14 weeks of benefits.

(9) The Tax Reform Act of 1986 (Public Law 99-514) made all unemployment compensation taxable under the Federal personal income tax.

(10) The Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) extended the 0.2 percent FUTA surtax for 3 years through 1990.

TABLE 14.—LEGISLATIVE CHANGES IN THE UNEMPLOYMENT COMPENSATION PROGRAM IN CALENDAR YEARS 1981, 1982, 1983, AND 1986

[In millions of dollars by fiscal years]

	1982	1983	1984	1985	1986	1987	1988
1981 (January 1982 estimates):							
Elimination of national trigger under the extended benefits program	−827	−1,273	−1,418				
Raise State triggers to 5 percent plus 120 percent or 6 percent	−0	−1,152	−448				
Claims for extended or additional compensation not included in determining rate of insured unemployment for extended benefit trigger calculation	−1,286	−1,283	−1,225				
Require 20 weeks of work or equivalent wages for extended benefits	0	−4	−3				
Limitations on unemployment benefits paid to ex-service members	−325	−376	−347				
Federal unemployment compensation loans to States	−5	−157	−350				
1982 (January 1983 estimates):							
Rounding UC benefits		−0	−22	−21	−20	−19	
Extend Reed Act		0	0	0	0	0	
Deferral of interest payment on UC loans		50	400	150	−250	−250	
Treatment of school employees		−7	−8	−9	−10	−11	
Short time compensation		1	1	0	0	0	
Unemployment benefits paid to ex-service members		132	111	117	109	101	
Taxation of unemployment compensation benefits		−763	−734	−611	−618	−650	
Federal supplemental benefits		2,570					
1983 (January 1984 estimates):							
Federal supplemental benefits			3,500	1,200			
Deferral of interest		37	85	−137	−474	−465	
1986 (1986 estimates):							
Sequestration of extended benefits					−1	0	0
Taxation of unemployment compensation						−230	−764

Note: Sign denotes impact upon deficit. (−) means deficit reduction.

Source: Congressional Budget Office.

TABLE 15.—EFFECT OF TAXING UNEMPLOYMENT COMPENSATION BENEFITS, BY INCOME CLASS, 1989

Level of individual or couple income [1]	Number of recipients of unemployment compensation (in thousands)	Number affected by taxation of benefits (in thousands)	Aggregate amount of unemployment compensation benefits (in billions of dollars)	Aggregate amount of taxes on benefits (in billion of dollars)	Taxes as a percent of benefits
Less than $10,000	1,604	588	2.2	.1	4.4
$10,000 to $15,000	1,040	935	1.5	.2	11.9
$15,000 to $20,000	938	906	1.3	.2	16.2
$20,000 to $25,000	798	776	1.2	.2	15.7
$25,000 to $30,000	767	764	1.1	.2	16.6
$30,000 to $40,000	1,062	1,062	1.5	.2	16.5
$40,000 to $50,000	579	579	.9	.2	19.2
$50,000 to $100,000	595	595	.9	.3	27.7
At least $100,000	37	37	.1	([2])	30.1
All	7,421	6,242	10.8	1.6	14.5

[1] Cash income (based on income of tax filing unit) plus capital gains realizations.

[2] Less than $50 million.

Note: Aggregate unemployment compensation benefits on the CPS are equal to only about two-thirds of total benefits paid out. The number of recipients is also understated on the CPS.

Source: Congressional Budget Office, based on data from the Current Population Survey (CPS).

APPENDIX F. STATISTICAL DATA ON UNEMPLOYMENT, EMPLOYMENT AND LABOR FORCE PROJECTIONS, DISLOCATED WORKERS, AND HISTORICAL INFORMATION ON THE UNEMPLOYMENT COMPENSATION PROGRAM

The following tables and charts provide statistical data on unemployment and historical information on the unemployment compensation program.

TABLE 1.—MONTHLY DATA FOR CIVILIAN UNEMPLOYMENT RATE AND INSURED UNEMPLOYMENT RATE SINCE 1970

Year	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Avg.
Civilian Unemployment Rate—Total (Seasonally Adjusted)													
1970	3.9	4.2	4.4	4.6	4.8	4.9	5.0	5.1	5.4	5.5	5.9	6.1	4.9
1971	5.9	5.9	6.0	5.9	5.9	5.9	6.0	6.1	6.0	5.8	6.0	6.0	5.9
1972	5.8	5.7	5.8	5.7	5.7	5.7	5.6	5.6	5.5	5.6	5.3	5.2	5.6
1973	4.9	5.0	4.9	5.0	4.9	4.9	4.8	4.8	4.8	4.6	4.8	4.9	4.9
1974	5.1	5.2	5.1	5.1	5.1	5.4	5.5	5.5	5.9	6.0	6.6	7.2	5.6
1975	8.1	8.1	8.6	8.8	9.0	8.8	8.6	8.4	8.4	8.4	8.3	8.2	8.5
1976	7.9	7.7	7.6	7.7	7.4	7.6	7.8	7.8	7.6	7.7	7.8	7.8	7.7
1977	7.5	7.6	7.4	7.2	7.0	7.2	6.9	6.9	7.0	6.8	6.8	6.4	7.1
1978	6.4	6.3	6.3	6.1	6.0	5.9	6.2	5.9	6.0	5.8	5.9	6.0	6.1
1979	5.9	5.9	5.8	5.8	5.6	5.7	5.7	6.0	5.9	6.0	5.9	6.0	5.8
1980	6.3	6.3	6.3	6.9	7.5	7.6	7.8	7.7	7.5	7.5	7.5	7.2	7.1
1981	7.5	7.4	7.4	7.2	7.5	7.5	7.2	7.4	7.6	7.9	8.3	8.5	7.6
1982	8.6	8.9	9.0	9.3	9.4	9.6	9.8	9.8	10.1	10.4	10.7	10.7	9.7
1983	10.4	10.4	10.3	10.2	10.2	10.1	9.4	9.4	9.2	8.8	8.4	8.2	9.6
1984	8.0	7.8	7.8	7.8	7.5	7.2	7.5	7.5	7.4	7.3	7.1	7.2	7.5
1985	7.4	7.3	7.2	7.3	7.2	7.3	7.3	7.1	7.1	7.1	7.0	7.0	7.2
1986	6.8	7.2	7.2	7.1	7.2	7.1	7.0	6.8	7.0	6.9	6.9	6.7	7.0
1987	6.7	6.7	6.6	6.3	6.3	6.1	6.0	6.0	5.9	6.0	5.9	5.8	6.2

Insured Unemployment Rate Under State Programs (Seasonally Adjusted)

1970	2.5	2.7	2.8	3.2	3.5	3.6	3.6	3.7	4.0	4.4	4.4	4.0	3.4
1971	3.9	3.9	4.0	4.1	4.1	4.1	3.9	4.2	4.3	4.2	4.1	4.0	4.1
1972	3.7	3.7	3.6	3.6	3.6	3.5	3.7	3.4	3.4	3.2	3.2	3.2	3.5
1973	2.9	2.8	2.8	2.6	2.7	2.7	2.6	2.8	2.7	2.7	2.7	2.9	2.7
1974	3.1	3.2	3.3	3.2	3.2	3.3	3.3	3.4	3.5	3.7	4.4	5.0	3.5
1975	5.6	5.8	6.4	6.7	6.9	6.8	6.1	5.9	5.8	5.6	5.3	4.9	6.0
1976	4.6	4.3	4.3	4.4	4.5	4.5	4.6	4.6	4.7	4.7	4.7	4.4	4.6
1977	4.3	4.2	4.1	4.0	3.9	3.9	3.8	3.8	3.8	3.8	3.8	3.7	3.9
1978	3.5	3.7	3.6	3.3	3.2	3.2	3.3	3.4	3.2	3.1	2.9	3.2	3.3
1979	3.1	3.2	3.1	3.0	2.8	2.8	2.8	3.0	2.9	3.0	3.1	3.2	2.9
1980	3.3	3.3	3.4	3.7	4.2	4.4	4.4	4.3	4.2	4.0	3.8	3.6	3.9
1981	3.5	3.5	3.4	3.3	3.3	3.3	3.3	3.3	3.4	3.6	3.9	4.0	3.5
1982	4.2	4.0	4.3	4.6	4.5	4.7	4.7	4.7	5.0	5.2	5.3	4.8	4.6
1983	4.5	4.7	4.5	4.4	4.2	3.9	3.7	3.5	3.4	3.3	3.3	3.2	3.9
1984	2.9	2.8	2.9	2.8	2.8	2.7	2.7	2.7	2.7	2.8	2.7	3.0	2.8
1985	2.8	3.0	3.0	2.9	2.8	2.8	2.8	2.8	2.8	2.6	2.8	2.9	2.8
1986	2.7	2.8	2.9	2.8	2.8	2.9	2.8	2.9	2.8	2.8	2.8	2.7	2.8
1987	2.6	2.6	2.6	2.5	2.4	2.4	2.4	2.3	2.3	2.1	2.2	2.2	2.4

TABLE 2.—STATE INSURED UNEMPLOYMENT RATES FOR CALENDAR YEARS 1982–86 AND RATES BY CALENDAR QUARTER FOR 1987 UNDER THE UNEMPLOYMENT COMPENSATION PROGRAM

[Percent]

	1982	1983	1984	1985	1986	1987			
						I	II	III	IV
Alabama	5.4	4.6	3.5	3.3	3.2	3.6	2.7	2.5	2.2
Alaska	7.1	6.7	6.2	7.1	8.0	9.0	7.1	4.8	5.6
Arizona	4.1	3.2	1.9	1.8	2.0	2.2	2.1	2.0	1.6
Arkansas	5.6	4.6	3.5	3.7	3.6	4.6	3.2	2.8	3.1
California	5.1	4.7	3.4	3.6	3.5	3.7	3.1	2.6	2.6
Colorado	3.0	3.1	2.1	2.3	2.5	3.2	2.5	1.9	1.9
Connecticut	3.4	2.9	1.8	1.8	1.6	2.0	1.2	1.2	1.0
Delaware	3.5	2.6	2.0	1.6	2.0	1.9	1.1	1.0	0.7
District of Columbia	3.6	3.2	2.5	2.1	2.1	2.3	1.9	1.9	1.7
Florida	2.5	2.1	1.4	1.4	1.6	1.2	1.1	1.3	1.0
Georgia	3.4	2.5	1.8	1.8	1.8	2.0	1.6	1.4	1.3
Hawaii	3.5	3.4	2.9	2.5	2.1	1.8	1.7	1.8	1.6
Idaho	7.1	5.6	4.2	4.5	4.8	6.3	3.9	3.3	3.3
Illinois	5.4	4.8	3.1	3.2	2.9	3.5	2.5	2.2	2.1
Indiana	4.7	3.7	2.5	2.3	2.1	2.6	1.6	1.4	1.3
Iowa	4.4	3.7	2.7	3.0	2.9	3.5	1.9	1.5	1.6
Kansas	4.0	3.1	2.2	2.4	2.7	3.1	2.2	2.1	2.0
Kentucky	5.8	4.9	3.3	3.3	3.2	3.5	2.2	2.0	1.9
Louisiana	4.5	5.2	3.9	4.4	5.3	5.6	4.3	3.6	3.0
Maine	4.7	4.5	3.7	3.5	2.9	3.4	2.3	1.8	1.6
Maryland	4.2	3.5	2.3	2.2	2.1	2.3	1.6	1.4	1.3
Massachusetts	3.9	3.2	2.3	2.4	2.5	2.5	1.6	1.6	1.4
Michigan	7.3	4.7	3.4	3.2	3.4	4.4	3.3	3.3	3.1
Minnesota	4.0	3.1	2.3	2.6	2.5	3.4	2.0	1.4	1.7
Mississippi	5.8	5.0	3.7	3.7	4.0	4.4	3.1	2.9	2.4
Missouri	4.3	3.5	2.5	2.6	2.6	3.2	2.2	2.1	2.0
Montana	5.2	4.8	4.1	3.9	3.9	5.2	3.3	2.3	2.6
Nebraska	2.7	2.7	2.0	2.3	2.1	2.8	1.7	1.3	1.3
Nevada	4.6	4.0	2.9	2.8	2.8	3.1	2.3	2.0	2.1
New Hampshire	2.8	2.2	1.5	1.0	0.8	0.9	0.5	0.5	0.4
New Jersey	4.7	3.9	3.1	2.9	2.6	2.9	3.1	2.0	1.7
New Mexico	3.8	4.0	2.9	2.8	3.4	3.6	3.2	2.5	2.3
New York	3.8	3.5	3.0	2.8	2.5	2.9	2.0	2.0	1.7
North Carolina	4.7	3.1	2.2	2.3	1.9	2.5	1.4	1.2	1.1
North Dakota	3.3	3.5	3.0	3.1	2.9	4.6	2.4	1.5	1.9
Ohio	5.8	4.2	3.0	3.0	2.8	3.4	2.3	2.0	2.0
Oklahoma	3.0	3.0	2.0	2.4	3.3	3.0	2.4	2.1	1.7

TABLE 2.—STATE INSURED UNEMPLOYMENT RATES FOR CALENDAR YEARS 1982–86 AND RATES BY CALENDAR QUARTER FOR 1987 UNDER THE UNEMPLOYMENT COMPENSATION PROGRAM—Continued

[Percent]

	1982	1983	1984	1985	1986	1987			
						I	II	III	IV
Oregon	7.0	5.5	4.3	4.6	4.9	5.0	3.5	2.6	3.0
Pennsylvania	6.6	5.9	4.2	4.0	3.6	4.1	2.8	2.4	2.3
Puerto Rico	8.9	7.2	6.3	7.1	5.7	5.7	4.6	4.6	4.7
Rhode Island	5.9	4.7	3.5	3.6	3.1	4.1	2.5	2.4	1.8
South Carolina	5.5	3.6	2.5	2.9	2.1	2.4	1.6	1.5	1.4
South Dakota	2.2	1.7	1.2	1.6	1.4	2.0	1.1	0.9	1.1
Tennessee	5.0	3.6	2.5	2.7	2.4	2.9	2.0	1.9	1.7
Texas	2.0	2.4	1.5	1.6	2.5	2.7	2.4	2.1	1.7
Utah	4.7	4.0	2.7	2.4	2.5	3.4	2.2	1.7	1.6
Vermont	5.0	4.3	3.2	3.1	2.5	3.0	2.1	1.3	1.4
Virginia	2.4	1.8	1.2	1.2	1.0	1.4	0.8	0.7	0.7
Virgin Islands	4.5	4.6	3.9	2.7	3.2	1.3	1.2	1.0	0.8
Washington	6.5	5.6	4.4	4.4	4.1	4.8	3.6	3.1	3.2
West Virginia	7.1	7.6	4.9	4.6	4.2	5.2	3.6	2.8	2.7
Wisconsin	5.8	4.7	3.4	3.5	3.0	4.2	2.4	1.9	2.1
Wyoming	3.6	4.4	2.3	2.4	3.9	5.3	3.4	1.9	2.1
United States	4.6	3.9	2.8	2.8	2.8	3.3	2.3	2.1	1.9

Prepared by DOL/ETA/UIS. Division of Actuarial Services.

TABLE 3.—SELECTED UNEMPLOYMENT RATES

[Monthly data seasonally adjusted]

Period	Unemployment rate (percent of civilian labor force in group)											
	Total (all civilian workers)	By sex and age			By race			By selected groups				
		Men 20 years and over	Women 20 years and over	Both sexes 16–19 years	White	Black	Black and other [1]	Experienced wage and salary workers	Married men, spouse present	Women who maintain families	Full-time workers	Part-time workers
1976	7.7	5.9	7.4	19.0	7.0	14.0	13.1	7.3	4.2	10.1	7.3	10.1
1977	7.1	5.2	7.0	17.8	6.2	14.0	13.1	6.6	3.6	9.4	6.6	9.9
1978	6.1	4.3	6.0	16.4	5.2	12.8	11.9	5.6	2.8	8.5	5.6	9.0
1979	5.8	4.2	5.7	16.1	5.1	12.3	11.3	5.5	2.8	8.3	5.3	8.8
1980	7.1	5.9	6.4	17.8	6.3	14.3	13.1	6.9	4.2	9.2	6.9	8.8
1981	7.6	6.3	6.8	19.6	6.7	15.6	14.2	7.3	4.3	10.4	7.3	9.4
1982	9.7	8.8	8.3	23.2	8.6	18.9	17.3	9.3	6.5	11.7	9.6	10.5
1983	9.6	8.9	8.1	22.4	8.4	19.5	17.8	9.2	6.5	12.2	9.5	10.4
1984	7.5	6.6	6.8	18.9	6.5	15.9	14.4	7.1	4.6	10.3	7.2	9.3
1985	7.2	6.2	6.6	18.6	6.2	15.1	13.7	6.8	4.3	10.4	6.8	9.3
1986	7.0	6.1	6.2	18.3	6.0	14.5	13.1	6.6	4.4	9.8	6.6	9.1
1987	6.2	5.4	5.4	16.9	5.3	13.0	11.6	5.8	3.9	9.2	5.8	8.4

[1] Category includes: American Samoans, Native Americans, Asians, and Black Hispanics.

Source: Department of Labor, Bureau of Labor Statistics.

TABLE 4.—SELECTED MEASURES OF UNEMPLOYMENT

Period	Unemployment (thousands)	Percent distribution of unemployment by duration [1]				Percent distribution of unemployment by reason [1]			
		Less than 5 weeks	5–14 weeks	15–26 weeks	27 weeks and over	Job losers	Job leavers	Reentrants	New entrants
1977	6,991	41.8	30.5	13.1	14.7	45.3	13.0	28.1	13.6
1978	6,202	46.2	31.0	12.4	10.4	41.7	14.1	29.9	14.3
1979	6,137	48.1	31.7	11.5	8.7	42.9	14.3	29.4	13.3
1980	7,637	43.1	32.3	13.8	10.7	51.7	11.7	25.2	11.4
1981	8,273	41.7	30.7	13.6	14.0	51.6	11.2	25.4	11.9
1982	10,678	36.4	31.0	16.0	16.6	58.7	7.9	22.3	11.1
1983	10,717	33.3	27.4	15.4	23.9	58.4	7.7	22.5	11.3
1984	8,539	39.2	28.7	12.9	19.1	51.8	9.6	25.6	13.0
1985	8,312	42.1	30.2	12.3	15.4	49.8	10.6	27.1	12.5
1986	8,283	41.0	32.0	12.4	14.5	47.9	13.0	25.7	13.4
1987	7,425	43.7	29.6	12.7	14.0	48.0	13.0	26.6	12.4

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[1] Detail may not add to 100 percent because of rounding.

TABLE 5.—UNEMPLOYMENT RATES BY STATE AND SELECTED METROPOLITAN AREAS

[In percent]

State and area	November		December	
	1986	1987	1986	1987p
Alabama	9.6	6.9	9.6	7.1
Birmingham	8.2	5.9	8.2	5.8
Huntsville	7.3	4.5	7.2	4.5
Mobile	10.3	8.8	10.6	9.1
Montgomery	7.9	6.1	7.4	5.8
Tuscaloosa	7.3	5.2	7.5	5.3
Alaska	10.6	9.6	11.2	9.7
Arizona	6.7	5.6	6.7	5.5
Phoenix	5.6	4.8	5.6	4.7
Tucson	5.8	4.7	5.8	4.6
Arkansas	8.9	7.7	9.1	7.9
Fayetteville-Springdale	4.5	3.8	4.9	4.6
Fort Smith[1]	6.9	6.2	7.1	6.1
Little Rock-North Little Rock	7.8	6.6	7.4	6.6
Pine Bluff	8.5	8.3	10.2	8.4
California[2]	6.5	5.1	6.3	4.9
Anaheim-Santa Ana	3.9	3.0	3.7	2.5
Bakersfield	12.9	10.4	12.3	8.7
Fresno	12.8	11.2	12.4	9.8
Los Angeles-Long Beach[2]	6.4	4.5	6.0	4.8
Modesto	13.7	11.8	13.9	11.2
Oakland	5.6	4.5	5.4	4.0
Oxnard-Ventura	7.2	5.5	6.7	4.6
Riverside-San Bernardino	6.3	5.5	6.0	4.6
Sacramento	6.1	5.4	6.2	5.1
Salinas-Seaside-Monterey	10.2	8.5	11.8	9.7
San Diego	5.1	4.4	4.8	3.7
San Francisco	4.4	3.4	4.1	3.0
San Jose	5.6	4.0	5.2	3.5
Santa Barbara-Santa Maria-Lompoc	5.5	4.7	5.4	4.1
Santa Rosa-Petaluma	5.2	4.6	5.1	4.5
Stockton	12.1	10.2	12.1	10.0
Vallejo-Fairfield-Napa	6.6	5.4	6.3	5.2
Colorado	7.6	6.7	7.7	6.8
Boulder-Longmont	5.6	5.2	5.8	5.3
Denver	7.0	6.2	7.1	6.3
Connecticut	3.3	3.2	3.4	3.1
Bridgeport-Milford	4.2	3.6	4.3	3.5
Hartford	2.9	3.0	3.2	3.2
New Britain	3.7	3.1	4.1	3.5
New Haven-Meriden	3.2	3.1	3.1	3.0
Stamford	2.3	2.2	2.4	2.1
Waterbury	4.6	4.0	4.8	3.7
Delaware	3.5	3.0	3.7	2.9
Wilmington[1]	3.9	3.0	4.1	3.1
District of Columbia	7.3	6.4	7.3	6.0
Washington[1]	3.2	3.1	3.2	2.9

See footnotes at end of table.

TABLE 5.—UNEMPLOYMENT RATES BY STATE AND SELECTED METROPOLITAN AREAS—Continued

[In percent]

State and area	November		December	
	1986	1987	1986	1987p
Florida[2]	5.6	5.1	4.6	5.0
Daytona Beach	5.2	5.1	4.6	4.4
Fort Lauderdale-Hollywood-Pompano Beach	4.4	4.1	3.5	3.9
Fort Myers-Cape Coral	4.0	3.7	3.1	3.2
Gainesville	3.4	3.3	2.9	3.1
Jacksonville	5.2	5.2	4.3	5.1
Lakeland-Winter Haven	9.5	8.1	7.4	7.3
Melbourne-Titusville-Palm Bay	7.1	5.0	5.7	4.4
Miami-Hialeah	6.5	5.6	5.2	5.4
Orlando	4.6	4.3	3.7	4.4
Pensacola	6.2	6.2	7.0	6.9
Sarasota	3.7	3.8	3.3	3.7
Tallahassee	3.5	3.8	3.1	3.7
Tampa-St. Petersburg-Clearwater	5.1	4.7	4.4	4.8
West Palm Beach-Boca Raton-Delray Beach	5.3	4.9	4.1	4.2
Georgia	5.6	5.4	5.7	5.4
Albany	10.9	8.6	10.7	8.9
Athens	4.5	4.3	5.1	4.6
Atlanta	4.5	4.7	4.4	4.4
Augusta[1]	5.9	5.3	6.1	5.4
Columbus[1]	7.2	6.3	7.2	7.4
Macon-Warner Robins	5.7	5.3	5.6	5.1
Savannah	6.1	6.1	6.1	6.0
Hawaii	4.6	3.8	4.2	3.7
Honolulu	4.3	3.3	3.8	3.4
Idaho	7.8	6.5	8.6	7.9
Boise City	5.4	4.9	5.9	5.4
Illinois[2]	6.9	6.3	7.0	6.9
Aurora-Elgin	5.4	4.4	5.6	5.1
Bloomington-Normal	4.6	4.6	4.7	5.3
Champaign-Urbana-Rantoul	4.0	3.9	4.1	4.4
Chicago	6.4	5.8	6.2	6.2
Davenport-Rock Island-Moline[1]	7.9	7.2	7.9	8.7
catur	8.9	8.6	8.6	8.9
iet	6.5	6.4	7.0	7.1
ankakee	8.1	8.9	8.3	9.9
Lake County	4.5	3.8	4.5	4.4
Peoria	7.3	6.7	7.8	7.1
Rockford	7.9	7.7	7.6	8.2
Springfield	4.9	5.3	4.9	5.9
Indiana	6.2	5.7	6.4	5.9
Anderson	5.9	6.0	6.4	6.5
Bloomington	3.0	3.8	3.5	3.8
Elkhart-Goshen	4.3	5.2	4.9	5.0
Evansville[1]	6.2	6.3	6.5	6.2
Fort Wayne	4.7	5.2	5.1	5.3
Gary-Hammond	12.3	7.4	12.1	7.5
Indianapolis	4.8	5.0	4.8	5.1
Kokomo	7.2	5.7	7.2	6.2

See footnotes at end of table.

TABLE 5.—UNEMPLOYMENT RATES BY STATE AND SELECTED METROPOLITAN AREAS—Continued

[In percent]

State and area	November		December	
	1986	1987	1986	1987p
Lafayette	3.4	4.1	3.6	3.6
Muncie	6.7	7.0	7.0	6.8
South Bend-Mishawaka	5.0	5.2	5.2	5.2
Terre Haute	6.3	5.9	6.7	5.9
Iowa	5.8	5.5	6.4	5.7
Cedar Rapids	5.0	4.9	5.2	4.7
Des Moines	4.7	4.1	4.9	4.1
Dubuque	6.2	7.1	7.5	6.8
Iowa City	1.9	2.2	2.2	1.9
Sioux City[1]	7.1	6.3	7.0	6.7
Waterloo-Cedar Falls	10.1	7.2	10.2	7.3
Kansas	5.1	4.7	5.4	5.1
Lawrence	3.2	3.6	3.5	4.5
Topeka	4.6	4.9	4.8	5.4
Wichita LMA	5.6	4.7	5.8	5.1
Kentucky	8.1	7.2	8.5	7.3
Lexington-Fayette	4.7	4.5	5.1	4.4
Louisville[1]	6.2	5.7	6.4	6.0
Owensboro	8.7	7.9	9.7	8.4
Louisiana	13.4	10.6	13.4	10.9
Alexandria	10.4	9.0	10.4	9.3
Baton Rouge	10.6	9.0	10.7	9.3
Houma-Thibodaux	19.1	12.4	18.7	12.6
Lafayette	15.5	10.5	15.3	10.4
Lake Charles	14.3	12.2	14.4	12.0
Monroe	10.6	9.4	10.5	9.5
New Orleans	11.1	9.4	10.9	9.4
Shreveport	12.6	10.2	12.8	10.7
Maine	4.4	3.5	4.3	3.5
Lewiston-Auburn	5.6	4.0	5.5	4.5
Portland	2.2	1.9	2.0	1.8
Maryland	4.0	4.1	4.2	4.2
Baltimore	4.6	4.5	4.8	4.8
Massachusetts[2]	3.6	2.3	3.1	2.6
Boston	3.1	2.0	2.6	2.3
Brockton	4.0	2.7	3.4	2.8
Fall River[1]	5.8	4.2	5.4	4.3
Fitchburg-Leominster	5.0	2.8	4.4	3.2
Lawrence-Haverhill[1]	4.6	3.4	4.1	3.6
Lowell[1]	4.2	2.6	3.5	2.7
New Bedford	5.8	3.6	5.1	4.0
Pittsfield	4.0	3.0	3.6	3.3
Springfield	3.9	2.3	3.4	2.6
Worcester	3.4	2.1	2.9	2.6
Michigan[2]	8.0	7.4	7.6	8.3
Ann Arbor	3.9	3.5	3.6	3.7

See footnotes at end of table.

TABLE 5.—UNEMPLOYMENT RATES BY STATE AND SELECTED METROPOLITAN AREAS—Continued

[In percent]

State and area	November		December	
	1986	1987	1986	1987p
Battle Creek	7.8	7.9	7.4	8.4
Benton Harbor	8.5	6.3	8.2	7.4
Detroit	7.7	7.3	7.0	8.0
Flint	10.2	13.6	9.4	14.0
Grand Rapids	7.0	5.4	6.7	6.2
Jackson	8.4	6.9	7.8	7.8
Kalamazoo	5.3	4.9	5.4	5.2
Lansing-East Lansing	6.3	5.8	6.0	6.5
Muskegon	11.0	8.6	10.8	9.3
Saginaw-Bay City-Midland	9.4	7.2	8.7	8.5
Minnesota	4.8	5.9	5.5	6.1
Duluth[1]	8.8	9.2	9.9	9.5
Minneapolis-St. Paul[1]	3.8	4.9	4.1	4.8
Rochester	3.8	5.1	4.0	4.3
St. Cloud	5.7	6.3	7.2	7.9
Mississippi	11.2	9.5	11.7	9.7
Jackson	8.0	6.6	8.1	6.4
Missouri	5.8	6.1	6.1	6.3
Kansas City[1]	4.4	5.3	4.5	5.6
St. Joseph	7.6	7.0	7.5	6.8
St. Louis[1]	6.5	6.5	6.6	6.5
Springfield	4.7	4.5	5.0	4.7
Montana	7.9	7.5	8.0	7.8
Nebraska	4.6	4.5	5.2	4.9
Lincoln	2.9	3.5	3.3	3.6
Omaha[1]	4.9	4.9	5.3	5.1
Nevada	5.5	6.1	6.0	6.7
Las Vegas	5.6	6.4	6.1	6.8
Reno	4.8	5.5	5.4	6.4
New Hampshire	2.4	2.2	2.5	2.2
Nashua	2.4	2.4	2.3	2.3
Portsmouth-Dover-Rochester	2.3	1.7	2.4	1.7
New Jersey[2]	4.1	3.2	3.9	3.6
Atlantic City	7.2	5.5	6.7	6.2
Bergen-Passaic	3.7	2.8	3.6	3.1
Jersey City	6.2	5.1	6.3	6.5
Middlesex-Somerset-Hunterdon	3.0	2.3	2.8	2.4
Monmouth-Ocean	3.4	2.7	3.3	3.0
Newark	4.4	3.4	4.1	3.6
Trenton	3.4	2.6	3.2	2.7
Vineland-Millville-Bridgeton	7.9	6.6	7.8	8.0
New Mexico	9.1	8.8	9.3	8.1
Albuquerque	6.6	7.0	6.5	6.1
Las Cruces	6.8	7.9	6.6	6.9
Santa Fe	5.5	5.6	5.7	5.5

See footnotes at end of table.

TABLE 5.—UNEMPLOYMENT RATES BY STATE AND SELECTED METROPOLITAN AREAS—Continued

[In percent]

State and area	November		December	
	1986	1987	1986	1987p
New York[2]	5.3	4.9	5.4	4.2
Albany-Schenectady-Troy	4.5	3.5	4.7	3.3
Binghamton	4.9	3.5	4.9	3.5
Buffalo	6.2	5.0	6.2	4.7
Elmira	5.5	3.9	5.6	3.4
Glens Falls	7.2	4.9	6.7	5.1
Nassau-Suffolk	3.8	3.0	3.6	2.7
New York	5.6	5.9	5.7	4.6
New York City[2]	6.1	6.6	6.2	5.0
Orange County	4.3	3.4	4.2	3.2
Poughkeepsie	3.2	2.9	3.1	2.6
Rochester	5.4	3.9	5.2	3.6
Syracuse	6.6	5.5	6.9	5.2
Utica-Rome	5.9	4.6	6.6	4.8
North Carolina[2]	5.4	4.0	4.8	4.2
Asheville	5.5	3.8	5.0	3.7
Charlotte-Gastonia-Rock Hill[1]	4.5	3.3	4.0	3.3
Greensboro-Winston Salem-High Point	4.6	3.4	3.9	3.3
Raleigh-Durham	3.6	3.0	3.1	2.9
North Dakota	6.3	5.2	6.6	5.8
Bismarck	6.5	5.8	6.9	6.0
Fargo-Moorhead[1]	3.8	3.9	4.0	4.5
Grand Forks	3.9	4.6	3.6	4.6
Ohio[2]	7.3	5.8	7.9	6.1
Akron	7.2	5.8	7.8	6.2
Canton	9.4	6.7	9.9	6.9
Cincinnati[1]	5.8	5.1	6.2	4.9
Cleveland	6.6	5.3	7.0	5.4
Columbus	5.6	4.8	5.8	4.9
Dayton-Springfield	6.0	4.8	6.4	5.1
Toledo	7.2	5.7	7.8	6.3
Youngstown-Warren	9.8	7.1	11.0	7.9
Oklahoma	8.1	6.4	7.9	6.1
Enid	7.9	5.9	8.0	5.5
Lawton	5.1	4.8	5.3	4.6
Oklahoma City	6.7	5.4	6.3	5.1
Tulsa	8.4	7.3	8.3	6.8
Oregon	7.9	5.6	8.2	6.1
Eugene-Springfield	7.5	5.6	8.0	5.9
Portland	6.9	4.8	7.0	4.9
Salem	8.0	5.7	8.8	6.7
Pennsylvania[2]	6.0	5.2	4.7	5.1
Allentown-Bethlehem[1]	5.6	4.2	4.2	4.3
Altoona	8.0	7.3	6.6	7.8
Beaver County	11.1	10.7	8.9	10.0
Erie	7.7	7.3	6.3	6.9
Harrisburg-Lebanon-Carlisle	3.6	3.1	2.7	2.8
Johnstown	8.6	8.4	7.4	8.7

See footnotes at end of table.

TABLE 5.—UNEMPLOYMENT RATES BY STATE AND SELECTED METROPOLITAN AREAS—Continued

[In percent]

State and area	November		December	
	1986	1987	1986	1987p
Lancaster	2.7	2.7	2.1	2.5
Philadelphia[1]	4.5	4.1	3.6	3.9
Pittsburgh	7.3	6.4	5.9	6.4
Reading	4.5	3.6	3.5	3.5
Scranton-Wilkes-Barre	7.3	6.3	6.1	6.3
Sharon	8.2	5.8	6.6	6.0
State College	5.4	4.9	4.5	5.0
Williamsport	6.2	4.9	5.3	5.3
York	4.3	3.4	3.3	3.0
Rhode Island	3.3	3.1	3.7	3.5
Pawtucket-Woonsocket-Attleboro[1]	4.0	3.3	4.3	4.0
Providence	3.2	3.0	3.6	3.4
South Carolina	5.9	4.5	5.9	4.8
Charleston	4.6	3.7	4.6	4.0
Columbia	3.9	3.4	3.6	3.4
Greeenville-Spartanburg	4.9	3.5	4.8	3.6
South Dakota	5.6	5.5	5.0	4.7
Rapid City	5.3	4.7	5.0	4.7
Sioux Falls	5.2	6.9	4.3	5.3
Tennessee	7.3	6.0	7.6	6.1
Chattanooga[1]	6.3	5.1	6.7	5.0
Johnson City-Kingsport-Bristol[1]	6.9	6.0	6.6	5.9
Knoxville	7.4	5.8	7.9	6.0
Memphis LMA[1]	6.6	5.5	6.5	5.4
Nashville	4.5	4.4	4.5	4.4
Texas[2]	8.8	7.9	8.7	6.8
Abilene	9.2	7.5	8.9	6.2
Amarillo	6.4	6.2	6.2	4.9
Austin	5.8	6.5	5.9	5.4
Beaumont-Port Arthur	12.6	11.1	12.3	9.9
Brazoria	10.4	8.7	10.4	7.6
Brownsville-Harlingen	14.4	14.5	14.7	12.9
Bryan-College Station	6.0	4.9	6.2	4.0
Corpus Christi	12.5	10.4	12.2	9.0
Dallas	5.8	6.2	5.7	5.2
El Paso	10.9	10.6	10.7	9.5
Fort Worth-Arlington	6.5	6.5	6.4	5.6
Galveston-Texas City	11.0	9.9	10.6	9.0
Houston	10.3	7.9	9.9	6.7
Killeen-Temple	7.6	7.8	7.6	6.6
Laredo	16.9	14.6	16.9	13.9
Longview-Marshall	11.2	9.5	11.5	8.5
Lubbock	6.3	5.6	6.0	5.1
McAllen-Edinburg-Mission	20.2	18.4	19.8	16.4
Midland	11.2	7.3	10.6	6.0
Odessa	16.0	7.7	15.2	6.4
San Angelo	7.0	5.9	6.7	5.2
San Antonio	7.7	7.8	7.5	6.8
Sherman-Denison	7.8	7.4	7.8	6.6

See footnotes at end of table.

TABLE 5.—UNEMPLOYMENT RATES BY STATE AND SELECTED METROPOLITAN AREAS—Continued

[In percent]

State and area	November		December	
	1986	1987	1986	1987p
Texarkana[1]	8.0	7.7	8.4	7.1
Tyler	9.0	8.2	9.4	6.9
Victoria	9.9	7.6	9.7	6.7
Waco	7.9	8.3	8.1	7.2
Wichita Falls	8.0	6.9	7.9	6.2
Utah	5.7	5.5	6.0	5.8
Provo-Orem	6.6	5.3	7.2	5.3
Salt Lake City-Ogden	5.0	5.2	5.2	5.5
Vermont	4.5	3.4	4.5	3.5
Burlington	3.2	2.4	3.0	2.3
Virginia	4.7	3.6	4.7	3.7
Charlottesville	3.4	2.1	4.0	2.3
Danville	8.0	6.1	8.1	6.4
Lynchburg	5.3	4.7	5.1	4.7
Norfolk-Virginia Beach-Newport News	4.8	4.0	4.7	4.0
Richmond-Petersburg	4.3	3.4	4.0	3.5
Roanoke	4.9	3.6	4.7	3.7
Washington	8.1	7.0	8.3	7.7
Seattle	6.3	5.5	6.2	5.9
West Virginia	11.0	10.8	11.6	11.4
Charleston	8.4	9.4	8.6	9.1
Huntington-Ashland[1]	9.3	8.9	10.2	9.7
Parkersburg-Marietta[1]	10.3	7.5	11.1	7.8
Wheeling[1]	10.6	8.2	11.0	9.1
Wisconsin	6.4	6.0	7.1	6.2
Appleton-Oshkosh-Neenah	6.4	5.7	7.2	5.7
Eau Claire	6.6	6.4	7.1	6.6
Green Bay	6.2	6.3	6.7	6.2
Janesville-Beloit	6.8	6.8	7.5	7.0
Kenosha	9.4	7.2	10.5	6.4
La Crosse	6.0	5.2	6.1	5.2
Madison	4.5	4.2	4.4	3.8
Milwaukee	5.5	5.1	5.8	5.3
Racine	7.3	6.4	8.7	6.4
Sheboygan	5.2	4.8	5.2	4.8
Wausau	7.1	6.2	7.5	6.4
Wyoming	9.3	7.1	9.7	7.7

NOTE: Data refer to place of residence. Estimates for 1986 have been benchmarked to 1986 Current Population Survey annual averages and may differ from data published earlier. Except in the 11 States and 2 areas designated by footnote 2, estimates for 1987 are provisional and will be revised when new benchmark information becomes available.

[1] Includes interstate portion of area located in adjacent State.

[2] Data are obtained directly from the Current Population Survey. (See "Explanatory Notes" for State and Area Labor Force Data in Employment and Earnings, Monthly.)

p = preliminary.

EMPLOYMENT AND LABOR FORCE PROJECTIONS

Labor Force Changes

The work force and nature of work in the 1990's will depend upon demographic, economic, social, and technical factors, among others. The discussion which follows is based upon Bureau of Labor Statistics projections prepared in 1987. Examined are changes in the population, labor force, industries, and occupations that are expected by 2000.

Population changes directly affect employment opportunities. As the size and characteristics of the population change, so does the nature of goods and services demanded. Population changes also influence the labor force and the difficulty or ease with which one can find a job. Of particular interest are the growth rate of the population, changes in the age structure of the population, and changes in the population centers of the Nation.

The post-World War II "baby boom" has been followed by a "baby bust." Consequently, we can expect a slower growing labor force and one in which the average age will creep upward. In 1986 the civilian labor force totaled just under 118 million. By 2000 the level is projected to be about 139 million. Additions to the labor force will be lower over the next decade because fewer teenagers are in the population and there is expected to be a slowdown in the number and proportion of women seeking jobs. Nevertheless, women are projected to account for 6 out of every 10 new entrants to the labor force (see table 6).

Some 2 out of every 10 new entrants through 1995 are expected to be black—a direct result of the higher birth rates of this group over the past few decades. Furthermore, the black labor force will be younger than the labor force in general. The aging of the babyboom, coupled with projected declines in labor force participation among older persons, will result in more than 70 percent of the labor force in 2000 being between the ages of 25 and 54 (prime-age workers). Currently, about 60 percent of the labor force is made up of this age group. In fact, the growth in the size of the prime-age labor force is projected to be greater than the increase in the total labor force. The size of both the younger and older labor force is expected to decrease (see table 7). Labor force participation of older persons is expected to decline as a larger percentage of workers become eligible for pensions and select early retirement (see table 7).

Population shifts are expected to continue to the South and West. While the West is projected to have the fastest rate of population growth, the South is projected to have the largest absolute population increase. Population levels in the Midwest are expected to remain stable while the population in the Northeast is expected to decline. Furthermore, the Northeast will have the oldest age distribution with nearly 15 percent of its population aged 65 and over. On the other hand, the West is projected to have the youngest distribution with more than one-fifth of its population below the age of 15 and nearly 70 percent below the age of 44. The South and Midwest age distributions are projected to be around the national average.

The differences in the regions described above have a direct effect on the nature of the labor market. Rapidly growing regions demand more public services and usually have high rates of construction. At the same time, however, the competition for jobs is stronger in these areas. Thus, it is important that regional differences be taken into account when examining national labor force and occupational projections.

Another factor that will have an impact on an individual's ability to find a job is their educational level. The overall educational level of workers has increased significantly over the postwar period. For example, nearly 50 percent of workers between the ages of 25 and 34 today have completed at least 1 year of college and more than 25 percent have 4 or more years of college. This clearly puts less educated workers at a distinct disadvantage. Nearly 25 percent of recent college graduates have had to accept a position that does not require a college degree.

Employment Changes

That service-producing industries are projected to grow faster than goods-producing industries is of little surprise. The Bureau of Labor Statistics predicts that more than 9 out of 10 jobs created over the next decade will be in service-producing industries (see table 8). This group includes the following industries: transportation, communications, and public utilities; trade (wholesale and retail); finance, insurance, and real estate; services; and government. The services industry is projected to create the most new jobs by 2000. Business services, including data processing, temporary help agencies, and building services are expected to grow faster and add more new jobs than any other industry. The trade sector is projected to be the next largest growing industry including retail trade (e.g., eating and drinking places), and wholesale trade.

Employment in goods-producing industries (mining, construction, manufacturing, and agriculture) is projected to increase quite modestly over the upcoming decade (see table 8). In fact, the projections show employment in 2000 not hitting the peak reached in 1979. Durable goods manufacturing (computers, machinery, and electric components), nondurable manufacturing (food processing, textile and apparel industries), agriculture, and mining are expected to lose jobs between 1986 and 2000. Employment in the construction industry is expected to grow modestly.

From an occupational perspective, employment growth through 2000 is expected to depart from historical trends. The Bureau of Labor Statistics suggests two ways of looking at occupational employment projections. One is by the actual number of jobs expected to be added and the other is by rate of growth (see tables 9 and 10). The distinction is important because occupations currently with large numbers of workers could add a significant number of jobs but show a relatively low growth rate. On the other hand, occupations with few workers could show high rates of growth but actually add few new jobs. The 20 occupations with the largest job growth are generally those requiring a low level of skills: e.g., cashiers, janitors and cleaners, truck drivers, waiters and waitresses, salesworkers, and food preparation workers (see table 9). This list does contain, however, computer programmers and computer systems analysts, which are also among the fastest growing occupations (see table 10). Nevertheless, computer and scientific and technical occupations account only for a small portion of the jobs that are projected to be added by 2000.

Just as there are occupations expected to grow over the next decade, there are occupations projected to decline. These are concentrated in industries which have been contracting over the past several years including apparel, textiles, railroad transportation, and agriculture. Other occupations are projected to decline because of changes in technology. These include stenographers, statistical clerks, and telephone installers and repairers.

Replacement

When one examines labor force and employment projections, one must also take into account job openings that will result from turnover or replacement needs. Openings take place when individuals transfer to new jobs, stop working (for various reasons), or retire. Jobs resulting from replacement needs are projected to be the source of most job openings. In 1983-84, the Bureau of Labor Statistics estimates that replacements accounted for 81 percent of all job openings.

Replacement needs vary significantly across occupations. Those that require little education and training have high separation rates. Many of these jobs are part-time and employ a large number of young workers. On the other hand, jobs requiring high educational levels or significant training have low replacement rates.

What is important to remember is that job replacement is the major source of employment opportunities in the U.S. economy. If the data for 1983-84 should be typical through 2000, we see that looking at employment growth by itself will not give a good indication of where the employment opportunities will develop over this time period.

TABLE 6.—CIVILIAN LABOR FORCE, BY SEX, AGE, AND RACE, ACTUAL 1972–86, AND MIDDLE GROWTH PROJECTIONS TO 2000

Group	Actual			Projected
	1972	1979	1986	2000
Total, 16 years and over (thousands)	87,037	104,960	117,837	138,775
Men	53,556	60,727	65,423	73,136
16 to 24	11,243	13,645	12,251	11,506
25 to 54	33,133	37,926	44,406	53,024
55 and over	9,180	9,156	8,766	8,606
Women	33,481	44,233	52,414	65,639
16 to 24	8,943	11,760	11,117	11,125
25 to 54	19,192	26,594	35,159	47,756
55 and over	5,346	5,879	6,138	6,758
White	77,275	91,922	101,801	116,701
Black	8,748	10,665	12,684	16,334
Asian and other		2,373	3,352	5,740
Hispanic		5,215	8,076	14,086
Total, 16 years and over (percent)	100.0	100.0	100.0	100.0
Men	61.5	57.9	55.5	52.7
16 to 24	12.9	13.0	10.4	8.3
25 to 54	38.1	36.1	37.7	38.2
55 and over	10.5	8.7	7.4	6.2
Women	38.5	42.1	44.5	47.3
16 to 24	10.3	11.2	9.4	8.0
25 to 54	22.1	25.3	29.8	34.4
55 and over	6.1	5.6	5.2	4.9
White	88.8	87.6	86.4	84.1
Black	10.1	10.2	10.8	11.8
Asian and other		2.3	2.8	4.1
Hispanic		5.0	6.9	10.2

Source: Bureau of Labor Statistics.

TABLE 7.—CIVILIAN LABOR FORCE AND PARTICIPATION RATES BY SEX, AGE, AND RACE, ACTUAL 1972–86, AND MIDDLE GROWTH PROJECTION FOR 2000

Group	Participation rate			Level (thousands)		
	Actual		Projected	Actual		Projected
	1972	1986	2000	1972	1986	2000
Total, 16 years and over	60.4	65.3	67.8	87,037	117,837	138,775
Men	79.0	76.3	74.7	53,556	65,423	73,136
16 to 19	58.1	56.4	60.2	4,478	4,102	4,501
20 to 24	83.9	85.8	87.5	6,765	8,149	7,005
25 to 34	95.7	94.6	93.6	12,349	19,383	16,559
35 to 44	96.4	94.8	93.9	10,372	15,029	20,133
45 to 54	93.2	91.0	90.1	10,412	9,994	16,332
55 to 64	80.4	67.3	63.2	7,155	6,954	7,238
65 and over	24.3	16.0	9.9	2,025	1,812	1,368
Women	43.9	55.3	61.5	33,481	52,414	65,639
16 to 19	45.8	52.9	59.2	3,578	3,824	4,379
20 to 24	59.1	72.4	78.4	5,365	7,293	6,746
25 to 34	47.8	71.6	82.3	6,609	15,209	15,098
35 to 44	52.0	73.1	84.2	6,028	12,204	18,438
45 to 54	53.9	65.9	75.4	6,555	7,746	14,220
55 to 64	42.1	42.3	45.8	4,257	4,940	5,732
65 and over	9.3	7.4	5.4	1,089	1,198	1,026
White	60.4	65.5	68.2	77,275	101,801	116,701
Men	79.6	76.9	75.3	48,118	57,216	62,252
Women	43.2	55.0	61.5	29,157	44,585	54,449
Black	60.2	63.5	66.0	8,748	12,684	16,334
Men	73.9	71.2	70.7	4,855	6,373	7,926
Women	48.8	57.2	62.1	3,893	6,311	8,408
Asian and other		64.9	65.8		3,352	5,740
Men		74.9	72.4		1,834	2,958
Women		55.9	60.1		1,518	2,782
Hispanic		65.4	68.7		8,076	14,086
Men		81.0	80.4		4,948	8,303
Women		50.1	56.9		3,128	5,783

Source: Bureau of Labor Statistics.

TABLE 8.—EMPLOYMENT BY MAJOR SECTOR, 1972–2000

Economic sector	Employment (in thousands)[1]			
	Actual			Projected[2]
	1972	1979	1986	2000 Moderate
Total	85,549	101,353	111,623	133,030
Nonfarm wage and salary	73,514	89,481	99,044	119,156
Goods-producing	23,668	26,463	24,681	24,678
Mining	628	958	783	724
Construction	3,889	4,463	4,904	5.794
Manufacturing	19,151	21,042	18,994	18,160
Durable	11,050	12,762	11,244	10,731
Nondurable	8,101	8,280	7,750	7,429
Service-producing	49,846	63,018	74,363	94,478
Transportation and public utilities	4,541	5,135	5,244	5,719
Wholesale trade	4,113	5,204	5,735	7,266
Retail trade	11,835	14,989	17,845	22,702
Finance, insurance, and real estate	3,907	4,975	6,297	7,917
Services	12,117	16,768	22,531	32,545
Government	13,333	15,947	16,711	18,329
Agriculture	3,523	3,401	3,252	2,917
Private households	1,693	1,326	1,241	1,215
Nonfarm self-employed and unpaid family workers	5,819	7,145	8,086	9,742
	Percent distribution of employment			
Total	100.0	100.0	100.0	100.0
Nonfarm wage and salary	86.9	88.3	88.7	89.6
Goods-producing	28.0	26.1	22.1	18.6
Mining	.7	.9	.7	.5
Construction	4.6	4.4	4.3	4.4
Manufacturing	22.7	20.8	17.0	13.7
Durable	13.1	12.6	10.1	8.1
Nondurable	9.6	8.2	6.9	5.6
Service-producing	59.0	62.2	66.6	71.0
Transportation and public utilities	5.4	5.1	4.7	4.3
Wholesale trade	4.9	5.1	5.1	5.5
Retail trade	14.0	14.8	16.0	17.1
Finance, insurance, and real estate	4.6	4.9	5.6	6.0
Services	14.3	16.5	20.2	24.5
Government	15.8	15.7	15.0	13.8
Agriculture	4.2	3.4	2.9	2.2
Private households	2.0	1.3	1.1	.9
Nonfarm self-employed and unpaid family workers	6.9	7.1	7.2	7.3

[1] Includes wage and salary jobs, the self-employed, and unpaid family workers.

[2] Under moderate scenario.

Source: Bureau of Labor Statistics.

TABLE 9.—OCCUPATIONS WITH THE LARGEST JOB GROWTH, 1986–2000

[Numbers in thousands]

Occupation	Employment		Change in employment 1986–2000		Percent of total job growth 1986–2000
	1986	2000	Number	Percent	
Salespersons, retail	3,579	4,780	1,201	33.5	5.6
Waiters and waitresses	1,702	2,454	752	44.2	3.5
Registered nurses	1,406	2,018	612	43.6	2.9
Janitors and cleaners, including maids and housekeeping cleaners	2,676	3,280	604	22.6	2.8
General managers and top executives	2,383	2,965	582	24.4	2.7
Cashiers	2,165	2,740	575	26.5	2.7
Truck drivers, light and heavy	2,211	2,736	525	23.8	2.5
General office clerks	2,361	2,824	462	19.6	2.2
Food counter, fountain, and related workers	1,500	1,949	449	29.9	2.1
Nursing aides, orderlies, and attendants	1,224	1,658	433	35.4	2.0
Secretaries	3,234	3,658	424	13.1	2.0
Guards	794	1,177	383	48.3	1.8
Accountants and auditors	945	1,322	376	39.8	1.8
Computer programmers	479	813	335	69.9	1.6
Food preparation workers	949	1,273	324	34.2	1.5
Teachers, kindergarten and elementary	1,527	1,826	299	19.6	1.4
Receptionists and information clerks	682	964	282	41.4	1.3
Computer systems analysts, electronic data processing	331	582	251	75.6	1.2
Cooks, restaurant	520	759	240	46.2	1.1
Licensed practical nurses	631	869	238	37.7	1.1
Gardners and groundskeepers, except farm	767	1,005	238	31.1	1.1
Maintenance repairers, general utility	1,039	1,270	232	22.3	1.1
Stock clerks, sales floor	1,087	1,312	225	20.7	1.0
First-line supervisors and managers	956	1,161	205	21.4	1.0
Dining room and cafeteria attendants and barroom helpers	433	631	197	45.6	.9
Electrical and electronics engineers	401	592	192	47.8	.9
Lawyers	527	718	191	36.3	.9

Source: Bureau of Labor Statistics.

TABLE 10.—FASTEST GROWING OCCUPATIONS, 1986–2000

[Numbers in thousands]

Occupation	Employment		Change in employment 1986–2000		Percent of total job growth 1986–2000
	1986	2000	Number	Percent	
Paralegal personnel	61	125	64	103.7	0.3
Medical assistants	132	251	119	90.4	.6
Physical therapists	61	115	53	87.5	.2
Physical and corrective therapy assistants and aides	36	65	29	81.6	.1
Data processing equipment repairers	69	125	56	80.4	.3
Home health aides	138	249	111	80.1	.5
Podiatrists	13	23	10	77.2	0
Computer systems analysts, electronic data processing	331	582	251	75.6	1.2
Medical records technicians	40	70	30	75.0	.1
Employment interviewers, private or public employment service	75	129	54	71.2	.3
Computer programmers	479	813	335	69.9	1.6
Radiologic technologists and technicians	115	190	75	64.7	.3
Dental hygienists	87	141	54	62.6	.3
Dental assistants	155	244	88	57.0	.4
Physician assistants	26	41	15	56.7	.1
Operations and systems researchers	38	59	21	54.1	.1
Occupational therapists	29	45	15	52.2	.1
Peripheral electronic data processing equipment operators	46	70	24	50.8	.1
Data entry keyers, composing	29	43	15	50.8	.1
Optometrists	37	55	18	49.2	.1

Source: Bureau of Labor Statistics.

DISLOCATED WORKERS

In recent years, the phrase "structurally unemployed" has become synonymous with "dislocated workers." Whether because of heightened international competition, more pervasive technological change, or continuing shifts in the pattern of domestic consumption, some adult workers with lengthy, stable work histories have lost and in some instances are still losing their jobs. Through no fault of their own, these individuals are being permanently laid off; they are unlikely to be recalled by their former employers as typically would be the case after recovery from a recession. Depending upon their skill level, demographic characteristics, and area of residence, some dislocated workers are likely to experience great difficulty finding other, comparable jobs.

During the back-to-back recessions of the early 1980's debate often occurred about whether the blue-collar factory workers being laid off in large numbers were all structurally unemployed, or whether most were cyclically unemployed and would have good reemployment prospects once the economy turned around. This debate prompted analysts to try to estimate the number of "truly" dislocated workers; i.e., those who would face dim reemployment opportunities even after an economic recovery. According to the various estimates made during the recession years, anywhere from as few as 100,000 to as many as 2.2 million persons might belong to the dislocated worker group, depending upon how it was defined.[1]

Because much of our knowledge about dislocated workers was indirect and anecdotal in the early 1980's, the U.S. Bureau of Labor Statistics (BLS) was asked to gather more precise information about the group. A special supplement to the Current Population Survey was designed and asked of survey respondents. The first survey's results cover the labor force experience of dislocated workers between January 1979 and January 1984; the second survey round covers their labor force activity between January 1981 and January 1986. The following analysis will examine the most recent survey's results and note differences between the earlier and later time periods when appropriate.[2]

Characteristics of the dislocated worker population

A total of 10.8 million workers age 20 or older lost jobs between January 1981 and January 1986 due to plant closings or relocations, slack work, or abolishment of a position or shift. More than half of those workers had not been at their jobs for a long period, however. Since dislocated workers, by widely accepted definition, are supposed to have had a strong attachment to their former jobs, the BLS established a cutoff of at least 3 years job tenure on the jobs that they lost. Based upon this criteria, in the 5-year period, there were about 5.1 million dislocated workers.

Most were in their prime working years, white, male, in blue-collar factory occupations, and living in the Midwest. As shown by the data in table 13, about half of the 5.1 million were men between 25 and 54 years old. Nearly three out of every five were white men. A similar proportion had worked in the unskilled and semiskilled blue-collar occupations of operators, fabricators, and laborers (36 percent) or the skilled blue-collar occupations of precision production, craft and repair (20 percent). Half had lost jobs in manufacturing industries, with one-third formerly employed by durable goods manufacturers (e.g., nonelectrical and electrical machinery, transportation equipment, primary metals). More than one out of five lived in the East North Central region, which includes Illinois, Indiana, Michigan, Ohio, and Wisconsin.

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[1] Bendick, Marc, and Judith Radlinski Devine. Workers Displaced by Economic Change: Do They Need Federal Employment and Training Assistance? In National Commission for Employment Policy. The Federal Interest in Employment and Training, Seventh Annual Report. Washington, 1981, p. 196; and U.S. Congressional Budget Office. Dislocated Workers: Issues and Federal Options. Washington, July 1982, p. 5, 38–39.

[2] Flaim, Paul and Ellen Sehgal. Displaced Workers of 1979–83: How Well Have They Fared? Monthly Labor Review, June 1985, p. 3–16; and U.S. Bureau of Labor Statistics. Reemployment Increases Among Displaced Workers, USDL 86–414. Washington, October 14, 1986. 12 p.

Their reemployment experience

By January 1986, 67 percent of dislocated workers had found new jobs. With two additional years of economic expansion (1984 and 1985), the proportion of dislocated workers with jobs in January 1986 was 7 percentage points higher than the level found in January 1984 among the first survey group. About 18 percent of the second survey group were still unemployed as opposed to 27 percent of the first group. The proportion of individuals no longer in the labor force remained unchanged between the two time periods, indicating that all of the improvement in dislocated workers' employment status was due to their finding jobs rather than their withdrawing from the labor force.

Some characteristics appear to be related to how successful dislocated workers are at becoming reemployed. Depending upon an individual's age, occupation, and geographic location, there was substantial variation around the overall reemployment rate of 67 percent.

Reemployment difficulties increased with age. Over 70 percent of workers between 20 and 54 years old had found new jobs, compared to just over 40 percent of workers age 55 or older. In addition, a large share of older workers left the labor force rather than continuing to look for work. This behavior was particularly true for older men, 40 percent of whom had left the labor force. Among these older men, labor force withdrawal was much more prevalent for those age 65 or older, some of whom probably chose retirement over unemployment.

The occupations of dislocated workers influenced their reemployment chances, as well. The more skilled the occupation of the worker, the data suggest, the greater the prospect of their having found work. Nearly three out of four managerial and professional workers, as well as a like proportion of technical workers, were in new jobs. Close to 7 out of 10 skilled blue-collar workers (i.e., those formerly in precision production, craft, and repair jobs) found other work. Alternatively, among the less skilled blue-collar group of operators, fabricators, and laborers, less than two-thirds were reemployed. Just over half of the workers formerly in service occupations found new jobs.

Area of residence also affected the likelihood of dislocated workers having found other employment. Just as workers who lost their jobs were concentrated in the East North Central region, one out of four dislocated workers still unemployed in January 1986 lived in the region. Moreover, of the 233,000 workers in the East North Central who remained jobless in January 1986, somewhat under one-third had been out of work at least 6 months.

The dependence of the East North Central's economy on so-called declining manufacturing industries has contributed to its low rate of reemployment.[3] The same dependence has hampered reemployment of dislocated workers in the Middle Atlantic, East South Central, and West North Central regions. Much of the regions' workers were employed by the primary metals, fabricated metals, nonelectrical machinery, and transportation equipment industries. During the two recessions to date in the 1980s, these manufacturing industries laid off large numbers of workers. Through 1986, manufacturing employment in several States comprising these regions (e.g., Illinois, Indiana, Iowa, Michigan, New Jersey, Ohio, and Pennsylvania) failed to regain prerecession (1979) levels. Contraction in these industries meant employment cutbacks in other industries that supplied them with raw materials, parts, and equipment. It also meant reduced spending and fewer jobs at area stores, restaurants, and other consumer-related establishments. As a consequence, dislocated workers in these regions faced a very slack and highly competitive labor market.

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[3] U.S. Library of Congress, Congressional Research Service. Employment Trends in the 1980s from a National, Industrial, and Geographic Perspective. CRS Report no. 86-130E, by Linda LeGrande and Mark Jickling. Washington, July 7, 1986, p. 13, 20-22, and 29.

Reemployment at comparable jobs?

While dislocated workers with new jobs are better off than their still unemployed counterparts, the new jobs do not necessarily afford them the standard of living which they previously had enjoyed. In many instances, the hours of work and wages for reemployed dislocated workers are less favorable in their new jobs.

Of the 3.2 million dislocated workers reemployed in January 1986, about 2.7 million previously held full-time jobs. Although most of these former full-time workers were able to obtain full-time jobs once again, 1 out of 10 (333,000) was reemployed on a part-time basis. Because they are now working fewer hours, their current earnings are apt to be substantially lower than their predisplacement, full-time pay.

Even among the nearly 2.7 million dislocated workers again employed in full-time wage and salary jobs, about 40 percent took pay cuts. The prevalence of pay cuts and the size of the cuts appear to be associated with the industries in which jobs were lost. Generally, former full-time manufacturing workers were the hardest hit: 44 percent were in lower paying jobs; 31 percent were in jobs paying at least one-fifth less than they previously earned. Among manufacturing workers, 61 percent of workers displaced from the relatively high-paying steel industry were earning less than they had on their former jobs.

In January 1984, the ending date of the first dislocated worker survey, there were almost 9 million unemployed individuals. Dislocated workers who were without jobs at that time accounted for 14.4 percent of national civilian unemployment. In January 1986, there were 7.8 million unemployed persons. Dislocated workers still jobless at that time accounted for 11.7 percent of the Nation's civilian unemployment. Thus, dislocated workers represent a relatively small, and decreasing, share of the Nation's jobless.

TABLE 11.—SELECTED INFORMATION ON THE REEMPLOYMENT EXPERIENCE OF DISLOCATED WORKERS, JANUARY 1986

Characteristic	Number who lost jobs (in thousands)	Percent distribution		
		Employed	Unemployed	Not in the labor force
Total, 20 years or older	5,130	66.9	17.8	15.3
20 to 24 years old	222	69.1	23.2	7.7
25 to 54 years old	3,950	72.5	18.1	9.4
65 years or older	169	23.4	4.3	72.4
Men, 20 years or older	3,321	70.9	18.6	10.5
Women, 20 years or older	1,810	59.6	16.2	24.1
Whites, 20 years or older	4,452	68.2	16.2	15.6
Blacks, 20 years or older	581	57.7	29.2	13.1
Hispanics, 20 years or older	311	56.6	27.2	16.1
Occupation of lost job:				
Managerial and professional	782	74.1	14.1	11.7
Technical, sales, and administrative support	1,125	68.0	12.8	19.2
Technicians and related	174	76.5	11.7	11.8
Sales	447	65.1	11.9	23.0
Administrative support, including clerical	504	67.6	13.9	18.5
Service occupations	254	53.5	22.6	23.9
Precision production, craft, repair	1,018	68.5	18.2	13.3
Operators, fabricators, and laborers	1,870	64.0	21.4	14.6
Farming, forestry, and fishing occupations	80	72.1	19.1	8.9
Industry of lost job:				
Private nonfarm, wage and salary workers	4,772	67.2	17.6	15.2
Mining	175	67.4	17.4	15.2
Construction	316	74.8	16.6	8.6
Manufacturing	2,550	65.9	18.2	15.9
Transport and public utilities	386	66.9	20.0	13.1
Wholesale and retail trade	689	66.3	12.4	21.3
Finance, insurance, and real estate	107	73.5	12.5	14.0
Services	540	68.4	21.4	10.2
Area of residence:				
New England	226	74.3	9.7	16.0
Middle Atlantic	733	60.3	22.1	17.6
East North Central	1,149	65.2	20.3	14.5
West North Central	384	68.5	16.1	15.4
South Atlantic	744	71.9	14.0	14.1
East South Central	397	62.5	21.2	16.3
West South Central	610	66.1	16.9	17.0
Mountain	240	72.5	14.2	13.3
Pacific	648	69.4	16.7	13.9

Source: U.S. Bureau of Labor Statistics. Reemployment Increases Among Displaced Workers, USDL 86–414. Washington, Oct. 14, 1986. 12 p.

HISTORICAL INFORMATION ON THE UNEMPLOYMENT COMPENSATION PROGRAM

TABLE 12.—EXHAUSTIONS—REGULAR STATE PROGRAMS

[In thousands]

	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987
January	162	169	152	147	229	332	261	211	184	215	309	258	421	269	238	290	229
February	158	168	127	129	230	295	251	184	160	201	275	267	394	245	207	208	218
March	188	184	143	146	278	326	290	201	193	220	291	341	470	251	228	231	245
April	182	171	138	167	369	305	265	192	185	259	289	362	431	245	253	256	244
May	167	179	141	178	406	273	242	193	195	251	246	338	398	243	235	233	206
June	180	159	119	159	438	282	254	176	162	246	244	378	383	198	194	214	204
July	164	149	119	190	487	263	215	151	169	298	247	360	336	213	235	245	210
August	161	153	124	174	413	254	234	158	166	256	215	365	341	212	205	212	179
September	149	121	100	145	370	239	198	138	140	254	207	351	264	163	182	210	171
October	136	117	111	155	350	212	183	133	161	292	200	347	244	197	208	223	161
November	140	123	110	152	291	231	192	144	159	259	201	384	249	183	180	183	153
December	154	120	112	186	336	251	192	149	162	319	265	424	248	188	214	241	NA
Total	1,942	1,811	1,495	1,926	4,195	3,262	2,776	2,030	2,037	3,072	2,989	4,175	4,180	2,607	2,579	2,746	NA

NA—Not available.

Source: U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance Service, Division of Actuarial Services.

TABLE 13.—STATE PROGRAM EXHAUSTIONS—EXTENDED BENEFITS

[In thousands]

	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987
January	10	52	366	177	126	11	24	169	9	91	7	4	5	9
February	9	50	215	166	66	10	15	128	14	95	6	4	6	0
March	10	100	244	187	50	13	18	134	38	128	7	*	5	5
April	13	161	253	177	45	15	28	117	114	153	6	7	5	1
May	62	207	190	159	49	31	74	95	134	156	12	9	4	2
June	65	228	197	170	49	19	66	90	193	120	3	5	3	2
July	55	245	175	141	50	13	67	48	128	44	1	5	8	1
August	41	245	178	92	38	12	64	21	121	23	*	6	14	1
September	38	271	180	94	23	11	139	23	126	11	*	5	8	0
October	47	294	174	137	30	14	208	15	126	7	1	4	8	0
November	46	258	187	136	12	12	147	14	93	6	3	3	7	NA
December	47	286	178	137	10	11	189	11	94	6	4	*	13	NA
Year total	441	2,398	2,536	1,774	549	172	1,039	862	1,188	840	50	52	86	NA

* Less than 500.
NA—Not available.

Source: U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance Service, Division of Actuarial Services.

TABLE 14.—BENEFIT EXHAUSTIONS UNDER FEDERAL SUPPLEMENTAL BENEFITS (1974–77) AND FEDERAL SUPPLEMENTAL COMPENSATION (1982–85)

[In thousands]

	Federal supplemental benefits					1978–81[1]	Federal supplemental compensation				
	1973	1974	1975	1976	1977		1982	1983	1984	1985	1986[1]
January	....	....	49	108	185	....	....	226	225	98	....
February	....	....	63	130	105	....	....	419	168	80	....
March	....	....	112	136	73	....	....	315	145	89	....
April	....	....	97	169	33	....	....	68	113	83	....
May	....	1	96	181	33	....	....	113	115	75	....
June	....	6	80	164	7	....	....	730	95	33	....
July	....	49	91	169	....	....	....	352	96	....	....
August	....	35	93	174	....	....	....	291	94	....	....
September	....	48	92	145	....	....	....	300	79	....	....
October	....	119	81	157	....	....	18	215	90	....	....
November	....	58	103	116	....	....	350	130	81	....	....
December	....	58	103	116	....	....	314	424	81	....	....
Total	....	374	1,060	1,765	436	....	682	3,583	1,382	458	....

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[1] There was no program in these years.

Note.—FSC exhaustions are not additive because reach back provisions caused claimants to receive as many as 3 final payments.

Source: U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance Service, Division of Actuarial Services.

TABLE 15.—UNEMPLOYMENT COMPENSATION BENEFITS PAID BY PROGRAM IN FISCAL YEAR 1987

[In millions of dollars]

State	Programs		Total
	Regular	Extended	
Alabama	182	0	182
Alaska	131	12	143
Arizona	130	0	130
Arkansas	138	0	138
California	1,970	0	1,970
Colorado	232	0	232
Connecticut	169	0	169
Delaware	27	0	27
District of Columbia	79	0	79
Florida	284	0	284
Georgia	252	0	252
Hawaii	50	0	50
Idaho	74	4	78
Illinois	867	0	867
Indiana	179	0	179

TABLE 15.—UNEMPLOYMENT COMPENSATION BENEFITS PAID BY PROGRAM IN FISCAL YEAR 1987—Continued

[In millions of dollars]

State	Programs		Total
	Regular	Extended	
Iowa	143	0	143
Kansas	175	0	175
Kentucky	155	0	155
Louisiana	462	78	540
Maine	54	0	54
Maryland	205	0	205
Massachusetts	436	0	436
Michigan	885	0	885
Minnesota	321	0	321
Mississippi	114	0	114
Missouri	235	0	235
Montana	51	0	51
Nebraska	54	0	54
Nevada	72	0	72
New Hampshire	14	0	14
New Jersey	603	0	603
New Mexico	82	0	82
New York	1,160	0	1,160
North Carolina	224	0	224
North Dakota	42	0	42
Ohio	690	0	690
Oklahoma	174	0	174
Oregon	238	0	238
Pennsylvania	1,016	0	1,016
Puerto Rico	97	9	106
Rhode Island	71	0	71
South Carolina	97	0	97
South Dakota	11	0	11
Tennessee	178	0	178
Texas	1,239	0	1,239
Utah	81	0	81
Vermont	26	0	26
Virginia	138	0	138
Virgin Islands	2	0	2
Washington	375	0	375
West Virginia	138	0	138
Wisconsin	345	0	345
Wyoming	60	4	64

Source: U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance, Division of Actuarial Service. Data include State programs and programs for Federal employees and ex-service members.

TABLE 16.—U.S. AVERAGE BENEFIT COST RATE: REGULAR STATE UI PLUS ½ EXTENDED BENEFIT AS PERCENT OF COVERED WAGES

Year	First quarter	Second quarter	Third quarter	Fourth quarter	Average
1971	1.52	1.19	1.05	1.06	1.20
1972	1.23	.92	.78	.72	.91
1973	.96	.72	.62	.66	.74
1974	1.13	.98	.89	1.13	1.03
1975	2.31	2.31	1.90	1.68	2.05
1976	1.85	1.42	1.28	1.30	1.46
1977	1.62	1.17	1.00	1.02	1.20
1978	1.19	.82	.73	.70	.86
1979	1.03	.77	.73	.81	.84
1980	1.23	1.23	1.32	1.21	1.25
1981	1.31	1.02	.93	1.09	1.09
1982	1.61	1.56	1.55	1.66	1.59
1983	1.87	1.42	1.02	.88	1.30
1984	1.03	.78	.68	.75	.81
1985	1.01	.81	.74	.77	.83
1986	.99	.83	.77	.78	.84
1987	.93	.72	.61	NA	NA

NA—Not available.

Note: 1971–74 EB data not available.

TABLE 17.—U.S. AVERAGE WAGE REPLACEMENT RATE: RATIO OF AVERAGE WEEKLY BENEFIT AMOUNT TO AVERAGE WEEKLY WAGE

Year	First quarter	Second quarter	Third quarter	Fourth quarter	Average
1971	0.347	0.346	0.344	0.356	0.348
1972	.356	.356	.355	.361	.357
1973	.354	.350	.343	.354	.350
1974	.349	.349	.358	.365	.355
1975	.352	.358	.366	.377	.363
1976	.363	.362	.356	.366	.362
1977	.358	.351	.347	.362	.354
1978	.360	.351	.345	.357	.353
1979	.350	.345	.345	.362	.351
1980	.350	.358	.359	.363	.357
1981	343	.346	.348	.363	.350
1982	.356	.362	.366	.377	.365
1983	.365	.364	.356	.357	.360
1984	.356	.355	.346	.357	.354
1985	.352	.350	.349	.359	.352
1986	.359	.361	.360	.363	.361
1987	.358	.358	.355	NA	NA

NA—Not available.

Prepared by DOL/ETA/UIS/DAS.

TABLE 18.—NUMBER UNEMPLOYED 27 WEEKS OR LONGER AS A PERCENT OF ALL UNEMPLOYED (UNADJUSTED)

	First quarter	Second quarter	Third quarter	Fourth quarter
1971	8.7	11.1	11.0	10.8
1972	12.1	13.5	10.8	9.8
1973	8.6	8.5	7.0	7.4
1974	6.8	8.3	7.5	7.1
1975	8.7	14.8	18.7	19.1
1976	19.7	20.1	16.7	16.3
1977	15.5	16.5	13.6	12.9
1978	11.1	11.8	10.1	8.7
1979	9.0	9.5	8.1	8.3
1980	8.3	9.9	11.1	13.5
1981	15.3	15.0	13.7	12.3
1982	13.0	16.7	17.1	19.4
1983	23.2	26.3	23.8	21.9
1984	21.0	21.0	17.7	16.5
1985	15.8	16.4	14.7	14.7
1986	13.8	15.0	14.6	14.2
1987	14.0	15.1	13.9	12.9

Source: U.S. Department of Labor.

Section 7. Aid to Families With Dependent Children (Title IV-A)

ELIGIBILITY

Aid to dependent children (ADC) was established by the Social Security Act of 1935 as a cash grant program to enable States to aid needy children without fathers. Renamed Aid to Families With Dependent Children (AFDC), the program provides cash welfare payments for needy children (and their mothers or other caretaker relatives), who have been deprived of parental support or care because their father or mother is absent from home continuously (85.2 percent of the children), is incapacitated (3.2 percent), is deceased (1.9 percent), or is unemployed (7.4 percent).[1]

States define "need," set their own benefit levels, establish (within Federal limitations) income and resource limits, and administer the program or supervise its administration. All States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands offer AFDC to needy children without able-bodied fathers at home, and 28 jurisdictions also offer Federal cash supplements to children in two-parent families who are needy because of the unemployment of one of their parents (Aid to Families With Dependent Children of Unemployed Parents (AFDC-UP)). Eligibility for AFDC on the basis of a parent's unemployment is limited to those families in which the principal wage earner is unemployed.

Eligibility for federally aided AFDC ends on a child's 18th birthday, or at State option upon a child's 19th birthday if the child is a full-time student in a secondary or technical school and may reasonably be expected to complete the program before he or she reaches age 19. Before passage of the Omnibus Budget Reconciliation Act (OBRA) of 1981, Public Law 97-35, a State could continue benefits through age 20 for students.

Federal law requires certain able-bodied recipients, including mothers whose youngest child is at least 6 years old, to register for work or job training. States may require work registrants to participate in one of several work programs: Work Incentive (WIN) Program; Community Work Experience Program (CWEP), Work Supplementation, or Job Search.

In 1981, Congress required that a portion of the income of a stepparent be counted in determining AFDC eligibility and benefit amounts. In 1984, a standard definition of the AFDC assistance unit was established for the first time. Under this requirement, the parent(s) in the home and all minor related children are to be included in the AFDC unit, with eligibility and benefits based on the income and circumstances of this family unit. SSI recipients and stepbrothers and stepsisters are excluded from this requirement and the first $50 of monthly child support received by the unit is disregarded when determining eligibility and benefits. In addition, if a minor who is living in the same home as her parents applies for aid as the parent of a needy child, the income of the minor's parents is to be counted as available to the filing unit.

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[1] Based on the 1986 HHS quality control case sample.

Finally, Federal law requires AFDC mothers to assign their child support rights to the State and to cooperate with welfare officials in establishing the paternity of a child born outside of marriage and in obtaining support payments from the father. AFDC also provides cash aid for foster care of AFDC-eligible children removed from their homes by judicial order and, under certain conditions, for those *voluntarily placed* in foster care.

TREATMENT OF EARNINGS

States are required by Federal law to disregard certain earned income when determining the amount of benefits to which a recipient family is entitled. Before OBRA, in order to provide a financial incentive for recipients to seek and maintain employment, Federal law required the deduction of an initial $30 in monthly earnings plus one-third of remaining earnings, plus work expenses (any expenses, including child care costs, reasonably attributable to the earning of income). When making an initial determination of eligibility, however, only work expenses were disregarded.

Amendments in OBRA changed the order in which the disregards were applied, limited the disregard for work expenses to $75 per month, capped the child care disregard at $160 per month per child, and specified that the HHS Secretary could lower these sums for part-time work. The $30 plus one-third disregard was allowed for only 4 consecutive months in a 12-month period. States were prohibited from paying AFDC to any family with a *gross* income above 150 percent of the State's standard of need and were required to assume that working AFDC recipients received a monthly earned income tax credit (EITC), if they appeared eligible for it and regardless of when or if the credit was actually available. Under prior law, the EITC was counted only when received; most AFDC recipients did not receive the EITC on a monthly basis. These changes substantially reduced the amount of earnings a recipient could have and remain eligible for an AFDC payment.

In 1984, Congress further revised these disregards. The gross income limit was increased to 185 percent of the State standard of need, the work expense disregard of $75 per month was applied to both full- and part-time workers, and the $30 disregard—originally a part of $30 and one-third—was extended for an additional 8 months beyond the 4-month limit on the one-third deduction. The 1984 legislation also returned to prior law policy with respect to the earned income tax credit: it is to be counted only when actually received.

Table 1 illustrates the impact of the 1981 and 1984 changes on a mother with two children working full-time at the minimum wage. The need and payment standard are assumed to be $420 per month, roughly equivalent to the payment level in a high benefit State or $359 per month, the maximum payment level in the median State for a family of three in January 1988.

TABLE 1.—CALCULATION OF BENEFITS FOR A FULL-TIME MINIMUM WAGE WORKER UNDER PRE-OBRA, OBRA, AND CURRENT LAW

	Pre-OBRA	OBRA		New law (DEFRA)		
		First 4 months	After 4 months	First 4 months	After 4 months	After 12 months
Income:						
Gross earnings	581	581	581	581	581	581
EITC		+32	+32			
Gross income	581	613	613	581	581	581
Disregards:						
Initial disregards [1]	−30	−105	−75	−105	−105	−75
One-third of rest	−194	(2)	(2)	(2)	(2)	(2)
Child care	−100	−100	−100	−100	−100	−100
One-third of rest	(2)	−136	0	−125	0	0
Other expenses	[3] −70	(2)	(2)	(2)	(2)	(2)
Total disregards	394	341	175	330	205	175
Net countable income	187	272	438	251	376	406
AFDC benefits:						
$420 payment standard	233	148	0	169	44	14
$359 payment standard	172	87	0	108	0	0

[1] Pre-OBRA: $30 disregard. OBRA: Standard work expense deduction of $75 plus $30 in first 4 months. New Law: Standard work expense deduction of $75 plus $30 disregard in first 12 months.

[2] Not applicable.

[3] Itemized work expenses including payroll deductions and transportation.

MONTHLY REPORTING AND RETROSPECTIVE BUDGETING

AFDC eligibility and benefits are determined monthly. Public Law 97-35 required States to determine eligibility on the basis of the family's circumstances in the current month; payment amounts were to be determined "retrospectively"—on the basis of the family's countable income and resources in the preceding month (or, at the discretion of the Secretary of Health and Human Services, the second preceding month). In addition, States were to require recipients to provide monthly reports on income, family composition, and resources. However, the Secretary could waive this requirement if the State demonstrated that it would be cost-beneficial to do so. The only categories of recipients that could not be exempted were those with earned income or a recent work history.

In 1984, Public Law 98-369 revised these monthly reporting and retrospective budgeting requirements. Retrospective budgeting is now mandatory only for cases which file a monthly report. Monthly reporting is required for cases with earned income or a recent work history and whenever cost effective.

WORK REQUIREMENTS AND PROGRAMS

As a condition of AFDC eligibility, persons 16 years of age or older, who are receiving or applying for AFDC, must register for work and training. An individual may be exempt from the work registration requirement if he or she is unable to participate due to illness, incapacity, advanced age, full-time student status, remoteness from a work incentive (WIN) program site, the need to care for an ill or incapacitated member of the household, or working at least 30 hours per week. Also exempt is the parent caring for a child under 6 years of age; in a two-parent family, one parent is exempt if the second parent is registered for work.

Work registration is one component of the work incentive (WIN) program. All States operate a WIN program or a WIN demonstration program. In addition, the act permits States to offer several other employment programs. These are: job search; the community work experience program, and work supplementation. Some States are also operating grant diversion programs and other innovative work programs under AFDC demonstration authority.

The WIN program and WIN demonstrations

The WIN program was established in 1967 with the purpose of providing skill assessments, job training, and employment placements to help AFDC recipients to become self-supporting (see tables 2–3). At the Federal level, the program is jointly administered by the Department of Labor and the Department of Health and Human Services. A dual administrative structure is also in place at the State level, unless the State has elected to operate a WIN demonstration project. These projects, authorized by OBRA (Public Law 97–35), permit States to design an alternative to WIN, administered solely by State welfare agencies. The Department of Health and Human Services oversees these demonstrations. Currently, 29 States are operating WIN demonstrations. Table 4 identifies the WIN demonstration States and the date the demonstration began.

In fiscal year 1981, Federal funding for the WIN program totaled $365 million. By fiscal year 1987, Federal WIN funding had declined to $110 million. Fiscal year 1988 funding totals $92.5 million. Funding limitations have restricted the States' ability to provide WIN services and training to AFDC recipients. As a result, many WIN registrants do not ever receive skills assessments, training, or job placements. As of September 1985, an estimated 1.6 million individuals were registered with WIN and WIN demonstration programs, of a total AFDC caseload of 3.7 million families.

AFDC recipients who are selected for participation in WIN must accept available jobs, training or needed services to prepare them for employment. Refusal to do so without good cause will result in a sanction. In the case of two-parent families, the entire family is made ineligible. In the case of a single parent who refuses to work, payment to the nonworking adult is denied, but protective payments continue for the children. Protective payments are payments to a third party. Usually a relative, neighbor or friend will receive the benefit check on behalf of the child; sometimes the State caseworker will serve as protective payee.

Effective for tax years beginning after December 31, 1981, WIN registrants and AFDC recipients were added to the list of target groups for whom employers can receive a targeted jobs credit. For tax years 1981–85, the credit was equal to 50 percent of up to

$6,000 in wages for the first year of employment and 25 percent of such wages for the second year. The Tax Reform Act of 1986 extended the credit through December 1988, but reduced the first year credit from 50 to 40 percent for up to $6,000 in qualified wages.

TABLE 2.—WIN PROGRAM DATA, FISCAL YEARS 1981, 1982, 1984–86

[Persons in thousands, dollars in millions]

	Fiscal year—				
	1981	[1] 1982	1984	1985	[6] 1986
New registrants [2]	1,156	903	1,016	1,013	870
Individuals entering unsubsidized employment [3]	310	204	354	340	260
Persons off welfare because employed [4]	169	144	178	170	130
6-month retention rate [5]	61.5	62.3	61	61	61
Welfare cost savings	$760	$521	NA	NA	NA
Appropriation	$365	$281	$259	$258	$203

[1] 11 States implemented in various months the WIN demonstration program during the latter part of fiscal year 1982.

[2] Registrations: FY 1984, 34 WIN regular, 18 WIN Demo States; FY 1985, 31 WIN regular, 23 WIN Demo States; FY 1986, 28 WIN regular, 26 WIN Demo States.

[3] Individuals entering unsubsidized employment whose employment was expected to last 30 days or more.

[4] Indicates number of individuals who completely went off welfare because of employment.

[5] Adjusted for GAO recommendations for fiscal year 1984 and beyond.

[6] Projections for 1986 using appropriated amounts as modified by Gramm-Rudman.

NA—not available.

Source: Data provided by U.S. Department of Labor; table compiled by Congressional Research Service.

Job search

The act permits States to require AFDC applicants and recipients to participate in a program of employment search beginning at the time of application. After an initial 8-week search period for applicants, AFDC recipients may be required to participate in 8 weeks of job search each year. This means that in the first year, up to 16 weeks of employment search may be required, with 8 weeks per year thereafter.

TABLE 3.—WIN REGISTRANTS AND JOB ENTRANTS BY SELECTED CHARACTERISTICS, FISCAL YEARS 1983–85

[In percentages]

	Fiscal year 1983		Fiscal year 1984		Fiscal year 1985	
	Registrants	Job entrants	Registrants	Job entrants	Registrants	Job entrants
Sex:						
Male	30	38	27	37	21	28
Female	70	62	73	63	79	72
Ethnic group:						
White	41	57	38	55	46	58
Black	34	25	36	26	42	34
Hispanic	18	14	19	15	9	5
Other	7	4	7	4	3	3
Years of school completed:						
0 to 8	16	9	17	9	14	7
9 to 11	36	31	36	31	38	32
12	37	45	37	46	38	47
Over 12	11	15	10	14	10	14
Age:						
Under 22	12	10	10	8	12	10
22 to 44	77	84	77	85	78	84
45 or older	11	6	13	7	10	6
Registrant status:						
Mandatory	91	89	91	91	88	84
Percent of mandatory which are unemployed parent	(22)	(29)	(20)	(21)	(14)	(22)
Voluntary	9	11	9	9	12	16

Source: Data provided by U.S. Department of Labor; table compiled by Congressional Research Service.

All WIN registrants, those exempt because they are remote from WIN sites, and applicants who appear to be WIN eligible may be required to participate in the job search program. At State option the job search requirement may be limited to certain groups or classes of individuals who are required to register for WIN. Transportation and other necessary costs incurred by participants must be reimbursed; States receive 50 percent Federal matching funds for these costs and may not use the job search requirement as a reason for delaying eligibility determinations or payments to those who are otherwise eligible. An individual who fails to comply with the job search requirement is subject to the sanctions described for the WIN program. Table 4 lists the States that have elected to require job search.

Community work experience program

Under authority granted by OBRA, States may operate community work experience programs (CWEP) if they so choose. These programs are commonly referred to as "workfare" and require adult AFDC recipients to perform some sort of community work, such as park beautification or as a teacher aide, in exchange for the AFDC benefit. The individual does not become a paid employee but, instead, works off the AFDC benefit. The number of hours a person works may not exceed their AFDC grant divided by the applicable minimum wage. CWEP participants do not receive the earned income disregards.

States may require CWEP participation by most AFDC recipients who are registered for WIN. However, unlike WIN, which exempts parents with children under the age of 6 from the work requirement, CWEP may require parents caring for children under age 6, but not under age 3, to participate if child care is available. As of September 1987, 28 States had opted to implement some kind of community work experience program. Most State workfare programs are not statewide. Table 4 identifies the States with a CWEP program. Table 5 presents estimates of monthly participation in CWEP and employment search programs.

Work supplementation and grant diversion

Finally, OBRA also permits States to operate work supplementation programs, in which AFDC may be used to subsidize a job for an AFDC recipient. In 1984, Congress amended the work supplementation provisions established by OBRA to give States greater flexibility. Under the original work supplementation program authorization, States could set their own eligibility requirements, adjust need standards and operate the program without regard to the regular statewideness and earned income disregard rules. Funds accrued from reducing the need standard or revising the earned income disregards were to be used to help defray the costs of subsidizing employment opportunities. However, the act limited Federal funding for an AFDC program which included a work supplementation component to that which would have been available to a State under its May 1981 State plan, adjusted for mandatory changes in Federal law and caseload changes within the State. Because of this restriction and the requirement that work supplementation jobs be limited to public or nonprofit organizations, States did not elect this option.

In 1984, the Deficit Reduction Act amended the work supplementation program requirements. Under the new law: (1) recipients may be placed in jobs offered by private as well as nonprofit employers; (2) States are permitted but not required to offer a $30 plus one-third earned income disregard for up to 9 months for participants; (3) Federal funding is limited to the aggregate of 9 months worth of unreduced welfare grants for each participant in the work supplementation program (or less if the person participates for fewer than 9 months); and (4) a State is permitted to develop its own method by which AFDC grants are diverted to wages and is not limited to prior law requirements. This permits States to pool the benefits of AFDC recipients actually participating in the program rather than diverting the grant on an individual case basis.

A number of States have also requested and received waivers, under section 1115 of the act, which permit them to operate a similar program called grant diversion. In a grant diversion program, States may use the AFDC benefit as a wage subsidy to encourage employers to hire AFDC recipients. Private, for-profit employers may participate in grant diversion. The wage subsidy is for a limited period, usually no more than 6 months. Currently 21 States are operating grant diversion or work supplementation programs. Table 6 summarizes these State programs.

TABLE 4.—STATE PARTICIPATION IN OPTIONAL AFDC WORK PROGRAMS

[Data as of September 1987]

State	Date WIN demo implemented	CWEP	IV–A job search
Alabama		Implemented in 1 county April 1982; now operating in 3 counties.	
Alaska			Implemented October 1986; now operating in 5 WIN areas.
Arizona	June 1, 1982		
Arkansas	Sept. 30, 1982	Implemented July 1987 in 46 counties.	Imlemented July 1987; now operating statewide.
California	Jan. 1, 1985	Implemented[1] in 1 county July 1981; now in 19 counties.	Implemented October 1985, now operating statewide.
Colorado		Implemented in 1 county September 1982; now operating in 26 counties.	
Connecticut	Oct. 1, 1985		Implemented statewide for UP recipients and mandatory WIN demo registrants who are determined to be job ready at assessments.
Delaware	Apr. 1, 1982		
District of Columbia.	July 1, 1987		Implemented July 1987.
Florida	Apr. 1, 1982		Implemented July 1985 in the 48 WIN demo counties.
Georgia	Jan. 1, 1985	Implemented in 10 counties August 1982; now operating in 20 counties.	Implemented January 1986; now operating in 20 WIN demo CWEP counties for recipients.
Idaho		Implemented in January 1982; now operating in 8 WIN areas.	
Illinois	July 1, 1982	Implemented in 12 counties in February 1984; now operating statewide.	Implemented July 1987 statewide
Indiana	Sept. 30, 1985		
Iowa	Sept. 30, 1983	Implemented for regular AFDC cases in 5 counties July 1982; currently operating in 74 counties for UP cases.	
Kansas		Implemented in 4 counties May 1983; currently operating in 24 counties.	Implemented for recipients only May 1983; now operating statewide.
Maine	Apr. 1, 1982		Implemented for recipients only January 1983; now operating in WIN demo areas for WIN demo registrants.
Maryland	Sept. 30, 1982		Implemented April 1982 in 8 areas.
Massachusetts	Apr. 12, 1982		Implemented for applicants and recipients in 16 counties October 1982. Statewide for UP's only.
Michigan	Apr. 1, 1982	Implemented July 1982; now operating statewide.	Implemented April 1987 statewide for recipients.
Minnesota		Implemented in 3 counties March 1983; now operating in 7 counties; for UP recipients.	Implemented April 1986; in CWEP counties; statewide for UP recipients.
Nebraska	Sept. 30, 1982	Implemented May 1986; now operating statewide.	Implemented March 1986; statewide.
Nevada		Implemented January 1987 in 3 counties.	
New Hampshire			Implemented October 1987.
New Jersey	Oct. 1, 1982	Implemented October 1987	Implemented October 1985; now statewide.

TABLE 4.—STATE PARTICIPATION IN OPTIONAL AFDC WORK PROGRAMS—Continued

[Data as of September 1987]

State	Date WIN demo implemented	CWEP	IV–A job search
New Mexico	July 1, 1987	Implemented September 1986 in 5 counties.	Implemented July 1987; now operating in 18 counties for recipients only.
New York	May 1, 1985	Implemented [1] January 1982; now operating in 35 counties and in New York City.	Implemented April 1987.
North Carolina		Implemented [1] in 6 counties January 1982; now operating in 34 counties.	
North Dakota		Implemented in 2 counties January 1982; now operating in 10 counties.	
Ohio		Implemented [1] in 4 counties March 1983; now operating in 29 counties.	Implemented for recipients only in 4 counties June 1986; now operating in 29 counties.
Oklahoma	Jan. 1, 1982	Implemented statewide January 1982.	Implemented statewide for applicants and recipients April 1983.
Oregon	Jan. 1, 1982	Considering for FY 88	Implemented for applicants and recipients statewide December 1982.
Pennsylvania	Sept. 30, 1982	Implemented [1] statewide March 1983 as part of WIN demonstration.	Implemented October 1986 statewide for applicants and recipients.
Rhode Island	July 1, 1987		Implemented for AFDC recipients and unemployed parents July 1985.
South Carolina		Implemented [1] in 2 counties May 1982.	Implemented for applicants and recipients statewide October 1985.
South Dakota	Apr. 1, 1982	Implemented in 40 counties April 1982; now operating statewide.	
Tennessee	Oct. 2, 1985		
Texas	Mar. 4, 1982		Implemented April 1983 for applicants and recipients, now operating statewide for recipients only.
Utah			Implemented for applicants and recipients statewide October 1984.
Vermont		Implemented April 1984; for UP cases active 6 mo. or more.	Implemented for UP applicants statewide April 1984.
Virginia	Jan. 1, 1983	Implemented [1] statewide as part of WIN demonstration January 1983.	Implemented statewide January 1983 for applicants and recipients.
Washington		Implemented [1] in 2 counties June 1982.	Implemented for applicants and recipients statewide October 1984.
West Virginia	Sept. 27, 1982	Implemented [1] statewide for UP's January 1982; now operating statewide for UP and regular AFDC recipients as part of WIN demonstration.	Implemented July 1986; statewide for all applicants and recipients as part of WIN demo.
Wisconsin	Sept. 30, 1983	Implemented statewide for recipients, August 1986.	Implemented statewide July 1986.

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[1] CWEP demonstration.

Source: Family Support Administration, January, 1988.

TABLE 5.—ESTIMATES OF MONTHLY PARTICIPATION IN AFDC WORK PROGRAMS

State	Fiscal year 1986		Fiscal year 1987	
	CWEP	Employment search	CWEP	Employment search
Alabama	580	0	0	0
Alaska	0	0	0	1,700
Arizona	0	0	0	0
Arkansas	0	0	0	0
California	0	0	6,700	9,000
Colorado	471	0	465	0
Connecticut	0	0	0	77
Delaware	0	0	0	0
District of Columbia	0	0	0	0
Florida	0	0	0	0
Georgia	400	0	0	25
Hawaii	0	0	0	0
Idaho	0	0	0	0
Illinois	0	0	0	0
Indiana	0	0	0	0
Iowa	837	0	627	0
Kansas	1,093	375	593	984
Kentucky	0	0	0	0
Louisiana	0	0	0	0
Maine	0	332	0	374
Maryland	0	0	0	0
Massachusetts	0	11,000	0	11,000
Michigan	0	0	0	0
Minnesota	153	0	95	32
Mississippi	0	0	0	0
Missouri	0	0	0	0
Montana	0	0	0	0
Nebraska	0	3,405	0	3,405
Nevada	0	0	70	0
New Hampshire	0	0	0	0
New Jersey	0	0	0	0
New Mexico	0	0	0	0
New York	11,444	7,505	14,977	7,500
North Carolina	3,976	0	9,978	0
North Dakota	138	0	138	0
Ohio	2,773	897	4,159	1,346
Oklahoma	2,500	6,000	933	495
Oregon	0	12,293	0	9,788
Pennsylvania	0	0	2,948	86,806
Rhode Island	0	750	0	760

TABLE 5.—ESTIMATES OF MONTHLY PARTICIPATION IN AFDC WORK PROGRAMS—Continued

State	Fiscal year 1986		Fiscal year 1987	
	CWEP	Employment search	CWEP	Employment search
South Carolina	56	47	46	317
South Dakota	269	0	280	0
Tennessee	0	0	0	0
Texas	0	5,310	0	6,612
Utah	771	7,723	1,189	1,013
Vermont	0	0	110	1,500
Virginia	21,750	0	0	22,000
Washington	8	1,364	7	1,719
West Virginia	4,700	0	5,039	0
Wisconsin	0	0	300	4,200
Wyoming	0	0	0	0
Guam	0	0	0	0
Puerto Rico	0	0	0	0
Virgin Islands	0	0	0	0
Total	51,919	57,001	48,654	170,653

Source: Family Support Administration.

TABLE 6.—STATE PARTICIPATION IN GRANT DIVERSION DEMONSTRATION PROJECTS AND WORK SUPPLEMENTATION PROGRAMS

[Data as of December 1987]

	AFDC for family of 3, 1987	Wage subsidy	Duration	Basis for subsidy/duration	Voluntary/mandatory	Location	Annual participation goal
California	633	50 percent	6 months average	Duration varies, 9 months maximum flat 50 percent.	Voluntary	1 county	50–70 participants.
Colorado	346	100 percent including other State/local funds.	8 week cycles	Fixed subsidy and duration (short term public employment).	Mandatory	1 county	500.
Connecticut	514	$1.75/hr	5 months maximum	Pool of diverted grant amount/duration based on consideration of reasonable coordination with State operations.	Voluntary	5 urban cities	687 participants.
Florida	264	33 percent AFDC; 50 percent JTPA; 83 percent total.	3 months average (up to 9 mos.).	Flat 50 percent JTPA flat amount AFDC ($190); duration—DOT code.	Voluntary	48 counties	No official goal.
Iowa	381	$200 per month	6 months	Variable	Mandatory once in program	8 counties	50 per year.

TABLE 6.—STATE PARTICIPATION IN GRANT DIVERSION DEMONSTRATION PROJECTS AND WORK SUPPLEMENTATION PROGRAMS—Continued

[Data as of December 1987]

	AFDC for family of 3, 1987	Wage subsidy	Duration	Basis for subsidy/duration	Voluntary/ mandatory	Location	Annual participation goal
Kansas	383	$250 per month	9 months	Variable	Mandatory once. in program	1 county	25 per year.
Maine	405	50 percent	6 months maximum may be after pre-vocational and field training.	Flat 50 percent; including JTPA contribution; duration based on DOT FVP code.	Voluntary	Majority of State.	No official goal.
Maryland	359	50 percent	4 month average	Flat 50 percent; duration may vary.	Voluntary	8 counties	200–250 participants; 250 job entries.
Massachusetts	476	Minimum 25%; maximum 50%.	Maximum 9 months; average 4 months.	Varies; duration 9 months.	Voluntary	Statewide	1,200 job entries.
Michigan	450	Maximum $400/ month.	6 months	No more than 50% of gross wages; maximum 6 months.	Voluntary	6 counties	1,050 job entries.
Minnesota	532	At least 50 percent from AFDC plus other funds (WIN, JTPA, State).	9 months	Diverted grant and other funds up to 50 percent of wages; duration 9 months.	Voluntary	17 counties	150.

New Jersey	404	50 percent	5 months average (9 months maximum).	Flat 50 percent; duration may vary.	Voluntary	9 counties	500.
New York	539	$250/month	6 months maximum	Flat amount ($250); duration may vary.	Mandatory	36 counties	1,552 job entries.
North Carolina	259	Divert full payment family of 2=$231; family of 4=$291.	9 months maximum	Must be on AFDC; Must receive AFDC payment equal to 5/81 level;. Must be mandatory WIN registrant.	Voluntary	1 county	No official goal.
Ohio	309	AFDC grant	9 months (maximum).	Entire grant diverted; duration may vary.	Voluntary	29 counties	300.
Oregon	412	$200/month maximum.	6 months maximum	Flat $200 if monthly wage $500 or more; if less, $1.15/hour of work.	Voluntary	Statewide	No official goal.
Oklahoma	310	$250/month	9 months maximum	Flat $250/month; 9 months duration.	Voluntary	Statewide	500.
Vermont	559	50 percent	Maximum 9 months Average 3.5 months.	Flat 50 percent; 9 month maximum based on DOT FVP code.	Voluntary	Statewide	200.
Virginia	303	Variable depending on wage and locality.	7 months average (5 months minimum); 9 months maximum.	Flat amount based on wage and locality not to exceed $270.	Voluntary	6 jurisdictions	120 job entries.

TABLE 6.—STATE PARTICIPATION IN GRANT DIVERSION DEMONSTRATION PROJECTS AND WORK SUPPLEMENTATION PROGRAMS—Continued

[Data as of December 1987]

	AFDC for family of 3, 1987	Wage subsidy	Duration	Basis for subsidy/duration	Voluntary/ mandatory	Location	Annual participation goal
Washington	492	50 percent	9 months maximum	Flat 50 percent	Voluntary	2 counties	No official goal.
Wisconsin	518	$400 per month	9 months	Flat subsidy of up to but not more than $400 per month based on FTE 32 hours per week.	Voluntary	Statewide	No official goal.

Source: Family Support Administration.

TREATMENT OF RESOURCES

Allowable resources are limited, by Public Law 97–35, to $1,000 (equity value) per family, excluding the home and one automobile if the family member's ownership interest does not exceed a limit chosen by the Secretary of Health and Human Services. HHS regulations set $1,500 as the equity value limit for the automobile and permit States to exclude from countable resources "basic items essential to day to day living," such as clothing and furniture. Previous regulations permitted States to adopt a counted resource limit as high as $2,000 per family member, but allowed States to consider the home and auto as counted resources.

AFDC FOR FAMILIES WITH UNEMPLOYED PARENTS (AFDC–UP)

The original Social Security Act permitted States to give AFDC only to needy children in one-parent homes, unless the second parent were incapacitated. Then, as now, most AFDC children lived in fatherless homes. For the first 25 years of the program, if a father lost his job and his family became needy, State AFDC programs were forbidden to help the family so long as he lived at home. In 1961, in an antirecession measure, the law was changed so that jobless fathers at home would not disqualify their families for welfare. Since May of that year States have been permitted to give AFDC to needy children of unemployed parents.

At first the States defined "unemployment," and some included fathers who worked as much as 35 hours a week, but since 1971 Federal regulations have specified that an AFDC parent must work fewer than 100 hours a month to be classified as unemployed.

Congress in 1981 (Public Law 97–35) specified that the qualifying unemployed parent must be the family's principal earner. Almost half of the 54 jurisdictions with AFDC programs never have used the option to give AFDC cash benefits to the unemployed and partly employed. The number of AFDC–UP State programs in recent years has ranged from 23 (December 1982) to 29 (September 1979), and in fiscal year 1987 was 28 jurisdictions. The States now participating contain about 71 percent of the Nation's total AFDC caseload, including most relatively high-benefit States. Expansion of AFDC eligibility to unemployed parents has been resisted, at least in some of the remaining States, because of the added costs.

During the 1970's, the AFDC–UP program served a monthly average of 120,000 families. In recent years the number of AFDC–UP families has risen sharply: fiscal year 1981, 209,000 families (monthly average); fiscal year 1982, 232,000; fiscal year 1983, 272,000, and fiscal year 1984, 287,000. In 1985, this dropped to 261,000 and in 1986 to 253,000. (See table 20.)

Enrollment for fiscal year 1987 again declined (see table 7). Some 236,156 families (1,035,140 persons) participated, well below the peak number of 287,000 families in 1984. AFDC–UP families in fiscal year 1987 averaged 4.4 persons, and they received payments averaging $531 per family, $121 per person.

TABLE 7.—AFDC–UP RECIPIENTS OF CASH PAYMENTS AND AMOUNTS OF PAYMENTS BY STATE, FISCAL YEAR 1987 (INCLUDES NONMEDICAL VENDOR PAYMENTS, PRELIMINARY DATA)

State	UP money payments (thousands)	Average number of families	Average number of recipients	Average payment per—	
				Family	Recipient
California [1]	$639,999	74,263	342,465	$718	$156
Connecticut	4,331	615	2,776	587	130
Delaware	206	61	252	280	68
District of Columbia	802	166	616	403	109
Guam [1]	312	113	611	231	43
Hawaii	4,518	815	3,911	462	96
Illinois	63,724	14,469	63,063	367	84
Iowa	22,492	4,661	19,344	402	97
Kansas	9,896	2,146	8,907	384	93
Maine	6,912	1,147	4,922	502	117
Maryland	4,763	946	4,164	419	95
Massachusetts	9,426	1,283	5,785	612	136
Michigan	183,944	28,029	119,014	547	129
Minnesota	51,568	7,456	33,208	576	129
Missouri	17,117	4,361	18,896	327	75
Montana	1,070	1,035	4,449	86	20
Nebraska	6,948	1,502	6,535	385	89
New Jersey [1]	15,086	2,944	13,393	427	94
New York [1]	72,921	11,924	51,716	510	118
Ohio	146,332	31,942	131,907	382	92
Oregon	6,011	1,415	5,909	354	85
Pennsylvania	41,277	10,808	46,534	318	74
Rhode Island	621	113	492	460	105
South Carolina	1,446	489	2,307	247	52
Vermont	3,485	586	2,442	496	119
Washington	48,094	7,658	32,548	523	123
West Virginia	37,309	10,368	42,631	300	73
Wisconsin	103,985	14,844	66,343	584	131
U.S. total	1,504,596	236,156	1,035,140	531	121

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[1] Money payments for July, August and September were taken from the SSA–3645, "Flash" Report for California, Guam and New Jersey. Caseload data for New Jersey and New York were also taken from this report.

Source: Family Support Administration.

INTERACTION BETWEEN AFDC AND OTHER PROGRAMS

Medicaid

States must provide Medicaid to families receiving cash assistance under AFDC. The Deficit Reduction Act of 1984 (Public Law 98–369) and the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99–272) also require States to extend this categorically needy Medicaid coverage, at regular Federal matching rates, to the following groups meeting AFDC income and resource requirements: (1) all pregnant women, regardless of family composition, from medical verification of pregnancy; and (2) children born on or after October 1, 1983, up to age 5. States may at their option extend Medicaid to pregnant women, infants and young children with income above the AFDC level but below the poverty level. States that do so are prohibited from lowering AFDC benefits.

When families lose AFDC eligibility, categorical Medicaid eligibility also frequently ends, except under certain circumstances. Prior to 1984, categorical Medicaid eligibility was retained after the loss of AFDC eligibility only in the case of families whose earnings increased to the point that they would be ineligible even if the $30 plus one-third disregard were applied. These families were eligible for Medicaid for 4 additional months. If a family lost eligibility for AFDC because of the 4-month limit on the $30 plus one-third disregard, it also simultaneously lost categorical eligibility for Medicaid.

Public Law 98–369 requires States to provide 9 months of Medicaid coverage to families who lose eligibility for AFDC due to the termination of the $30 plus one-third disregard. States have the option of extending this coverage for an additional 6 months in the case of a family that would be eligible for AFDC if the $30 plus one-third disregard were applied. Families who lose AFDC due to an increase in earnings continue to be eligible for 4 months of Medicaid benefits. In addition, the Child Support Enforcement Amendments of 1984 (Public Law 98–378) require States to provide 4 months of Medicaid coverage to AFDC families who lose eligibility due to receipt of child support payments.

Families who do not meet the criteria established in the 1984 amendments discussed above, and those who have exhausted these benefits, may also qualify for medically needy programs which are offered by 33 States and the District of Columbia. However, many State medically needy programs are less comprehensive than the basic Medicaid program and are of greatest benefit to families who incur large medical expenses.

Food stamps

Most AFDC families are also eligible for and participate in the food stamp program, which provides an important in-kind supplement to the cash assistance paid under AFDC. Although food stamp benefits are not counted in determining AFDC eligibility, the food stamp program does consider AFDC payments to be countable income and reduces the food stamp benefit by $0.30 for each dollar of countable cash income. This interaction between AFDC and the food stamp program has important financial implications for a State which desires to increase the income of its AFDC recipients. Because food stamps are reduced by $0.30 for each additional

$1 of AFDC income, the State must expend $1.43 to obtain an effective $1 increase in AFDC recipients' total income. For a State with a 50 percent matching rate, the State must expend $0.72 to actually obtain a $1 increase in recipient income. This would be the typical situation for an AFDC recipient with no earnings.

Table 8 illustrates the interaction of various programs for a mother with two children at various earning levels. The example assumes the family lives in Pennsylvania, which pays AFDC benefits slightly above average; calculations are made after the mother has been working for 4 months and lost the $30 plus one-third earned income disregard.

TABLE 8.—EARNINGS AND BENEFITS FOR A MOTHER WITH TWO CHILDREN WITH DAYCARE EXPENSES—AFTER 4 MONTHS ON JOB (JANUARY 1988)—(PENNSYLVANIA)

Earnings	EITC	AFDC [1]	Food stamps [2]	Medicaid	Taxes			Work expenses [4]	"Disposable" income
					Social security	Federal income [3]	State income		
0	0	$4,824	$1,656	Yes	0	0	0	0	[5] $6,480
$2,000	$280	4,204	1,414	Yes	$150	0	0	$600	[5] 7,148
$4,000	560	2,324	1,551	Yes	300	0	0	1,200	[5] 6,935
$5,000	700	1,384	1,620	Yes	376	0	0	1,500	[5] 6,828
$6,000	840	444	1,688	Yes	451	0	0	1,800	[5] 6,721
$7,000	874	0	1,633	Yes	526	0	0	2,100	[5] 6,881
$8,000	874	0	1,453	[6] Yes	601	0	$168	2,400	[5] 7,158
$9,000	874	0	1,273	[6] Yes	676	0	189	2,700	[5] 7,582
$10,000	858	0	1,074	[7] No	751	0	210	3,000	7,971
$15,000	358	0	0	No	1,127	$712	315	4,200	9,004
$20,000	0	0	0	No	1,502	1,463	420	5,040	11,575
$30,000	0	0	0	No	2,253	2,963	630	5,040	19,114
$50,000	0	0	0	No	3,380	5,963	1,050	5,040	34,567

[1] Assumes these deductions: $105 monthly standard allowance (which would drop to $75 after 1 year on the job) and child care costs equal to 20 percent of earnings, up to maximum of $320 for 2 children.

[2] Assumes these deductions: 20 percent of earnings (including EITC as earnings), $102 monthly standard deduction and child care costs equal to 20 percent of wages, up to maximum of $160 monthly.

[3] Head of household rates in effect for 1988.

[4] Assumed to equal 10 percent of earnings up to maximum of $100 monthly, plus child care costs equal to 20 percent of earnings up to the maximum allowed by AFDC ($320 for 2 children).

[5] In addition, the benefits from Medicaid could be added, but are not. Medicaid, in fiscal year 1985 cost about $1,854 for a 3-person AFDC family (national average). In Pennsylvania, the cost of Medicaid for a 3-person family in fiscal year 1985 was $1,537.

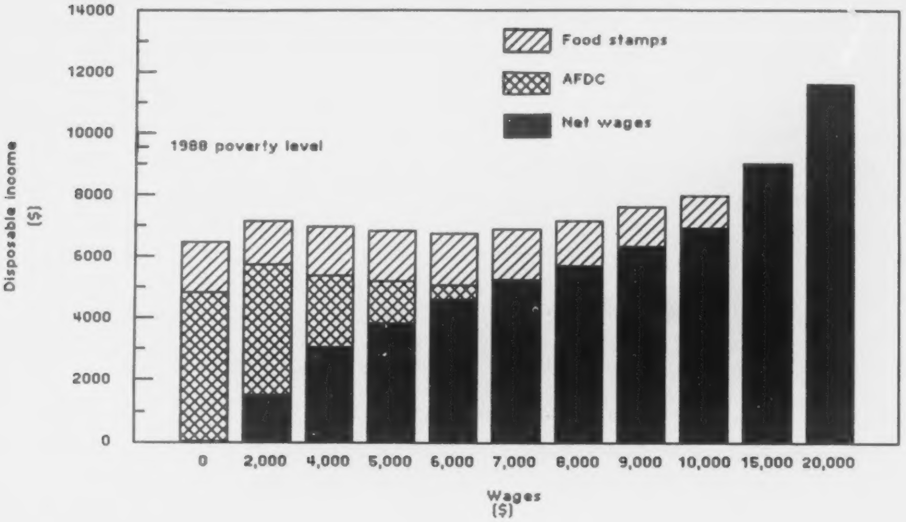
[6] Family would qualify for Medicaid for 9 additional months under 1984 Federal law, which requires State to continue Medicaid that long for a family whose earnings removed them from AFDC, provided the family would have retained AFDC eligibility if one-third of residual earnings had been disregarded beyond 4 months.

[7] To regain Medicaid eligibility, family must spend down on medical expenses to State's medically needy limit ($5,100, as of January 1986).

Note: Under IRS rules, unless earnings at least equal AFDC, the mother generally is not a "head of household" eligible for EITC; but it appears that this rule is rarely applied. Example assumes the rule is not applied.

Source: Congressional Research Service.

DISPOSABLE INCOME AT VARIOUS WAGE LEVELS, FOR A MOTHER WITH TWO CHILDREN WITH CHILD CARE EXPENSES, PENNSYLVANIA, JANUARY 1988



SSI and Social Security

In AFDC, Social Security benefits are treated as unearned income and thus AFDC benefits are reduced by $1 for each $1 of OASDI benefits. SSI benefits received by a potential member of an AFDC family are treated differently. This member (both a child or an adult receiving SSI benefits) is not regarded as a part of the AFDC unit. Thus his needs are not taken into account in determining the AFDC benefit level. At the same time, the income and resources of the SSI recipient are also ignored in determining the AFDC benefit.

CURRENT BENEFIT LEVELS AND TRENDS

Each State establishes a "need standard" (the income the State decides is essential for basic consumption items) and a "payment standard" (100 percent or less of the need level). Benefits are generally computed by subtracting countable income from the State's payment standard.

Maximum payments

Maximum AFDC payments vary sharply from State to State, as shown by tables 9 and 10. State payments for AFDC families of three with no countable income in January 1988 ranged from $118 in Alabama to $779 in Alaska. Table 9 presents the gross income limit, the need standard, and the maximum monthly potential AFDC and food stamp benefits for a one-parent family of three persons, as of January 1988.

The food stamp benefits are calculated by deducting from the family's AFDC benefit (the only cash income of the family) the maximum deductions allowed under food stamps for a nonaged, nondisabled family: a total of $266. This consists of a standard deduction of $102, given in all households, plus a deduction of $164 for excess shelter costs.

If the family qualified only for the standard deduction, its food stamp benefits would be cut in most States by about $48. Table 9 shows combined maximum potential benefits of $612 to a New Jersey AFDC family of 3, including $188 in food stamps. The same family would receive only $562 in combined benefits, including $138 in food stamps, if it were credited only with the standard deduction. Food stamp program data show that most AFDC families do qualify for a deduction of some shelter costs.

As table 12 illustrates, during 1987, 33 States increased AFDC payments. Sixteen increased benefits by $15 or more per month. Twenty-two jurisdictions had no payment increases. One State—Wisconsin—decreased AFDC benefits. As a result of the increases, the median State benefit for a family of three increased from $354 to $359 per month in nominal dollars.

TABLE 9.—GROSS INCOME LIMIT, NEED STANDARD, AND MAXIMUM MONTHLY POTENTIAL BENEFITS, AFDC AND FOOD STAMPS, ONE-PARENT FAMILY [1] OF THREE PERSONS, JANUARY 1988

State	Gross income limit (185 percent of need standard)	100 percent of "need"	Maximum AFDC grant [2]	Food stamp benefit [3]	Combined benefits	Combined benefits as a percent of 1987 poverty threshold [4]	AFDC benefits as a percent of 1987 poverty threshold
Alabama	$710	$384	$118	$228	$346	46	16
Alaska	1,441	779	779	201	980	104	83
Arizona	1,149	621	293	219	512	68	39
Arkansas	1,286	695	202	228	430	57	27
California	1,171	633	633	117	750	99	84
Colorado	779	421	356	201	557	74	47
Connecticut	1,112	601	601	127	728	96	80
Delaware	590	319	319	212	531	70	42
District of Columbia	1,317	712	379	194	573	76	50
Florida	1,434	775	275	225	500	66	36
Georgia	677	366	263	228	491	65	35
Hawaii	953	515	515	308	823	95	68
Idaho	1,025	554	304	216	520	69	40
Illinois	1,319	713	[5] 342	210	552	73	45
Indiana	592	320	288	221	509	67	38
Iowa	919	497	381	193	574	76	50
Kansas	757	409	[5] 409	195	604	80	54
Kentucky	383	207	207	228	435	58	27
Louisiana	1,169	632	190	228	418	55	25
Maine	1,060	573	416	183	599	79	55

TABLE 9.—GROSS INCOME LIMIT, NEED STANDARD, AND MAXIMUM MONTHLY POTENTIAL BENEFITS, AFDC AND FOOD STAMPS, ONE-PARENT FAMILY [1] OF THREE PERSONS, JANUARY 1988—Continued

State	Gross income limit (185 percent of need standard)	100 percent of "need"	Maximum AFDC grant [2]	Food stamp benefit [3]	Combined benefits	Combined benefits as a percent of 1987 poverty threshold [4]	AFDC benefits as a percent of 1987 poverty threshold
Maryland	919	497	[5] 359	217	576	76	48
Massachusetts	944	510	510	154	664	88	68
Michigan (Washtenaw County)	1,232	666	[5] 558	162	720	95	74
Michigan (Wayne County)	1,166	630	[5] 528	171	699	93	70
Minnesota	984	532	532	148	680	90	69
Mississippi	681	368	120	228	348	46	16
Missouri	577	312	282	223	505	67	37
Montana	803	434	359	200	559	74	48
Nebraska	648	350	350	202	552	73	46
Nevada	1,018	550	325	210	535	71	43
New Hampshire	899	486	486	162	648	86	64
New Jersey	784	424	[5] 424	188	612	81	56
New Mexico	488	264	264	228	492	65	35
New York (Suffolk County)	1,230	665	[5] 665	124	789	105	88
New York (New York City)	997	539	[5] 539	162	701	93	71
North Carolina	984	532	266	228	494	65	35
North Dakota	686	371	371	196	567	75	49
Ohio	1,267	685	[5] 309	219	528	70	41
Oklahoma	871	471	310	214	524	69	41
Oregon	762	412	[5] 412	219	631	84	55
Pennsylvania	1,136	614	402	187	589	78	53
Rhode Island	931	503	[5] 503	195	698	92	67
South Carolina	718	388	200	228	428	57	26
South Dakota	677	366	366	198	564	75	48
Tennessee	653	353	159	228	387	51	21
Texas	1,062	574	184	228	412	55	24
Utah	1,282	693	376	195	571	76	50
Vermont	1,645	889	603	126	729	97	80
Virginia	727	393	354	201	555	74	47
Washington	1,545	835	[5] 492	174	666	88	65
West Virginia	919	497	249	228	477	63	33

TABLE 9.—GROSS INCOME LIMIT, NEED STANDARD, AND MAXIMUM MONTHLY POTENTIAL BENEFITS, AFDC AND FOOD STAMPS, ONE-PARENT FAMILY [1] OF THREE PERSONS, JANUARY 1988—Continued

State	Gross income limit (185 percent of need standard)	100 percent of "need"	Maximum AFDC grant [2]	Food stamp benefit [3]	Combined benefits	Combined benefits as a percent of 1987 poverty threshold [4]	AFDC benefits as a percent of 1987 poverty threshold
Wisconsin	1,197	647	517	152	669	89	68
Wyoming	666	360	360	199	559	74	48
Guam	490	265	265	336	601	80	35
Puerto Rico	333	180	90	NA	NA	NA	12
Virgin Islands	387	209	171	293	464	61	23
Median AFDC State [6]	803	434	359	200	559	74	48

[1] In most States these benefit amounts apply also to 2-parent families of 3 (where the second parent is incapacitated, or, as permitted in almost half the States, unemployed). Some, however, increase benefits for such families.

[2] In States with area differentials, figure shown is for area with highest benefit.

[3] Food stamp benefits are based on maximum AFDC benefits shown and assume deductions of $266 monthly ($102 standard household deduction plus $164 maximum allowable deduction for excess shelter cost) in the 48 contiguous States and D.C. In the remaining five jurisdictions these maximum allowable food stamp deductions are assumed: Alaska, $460; Hawaii, $378; Guam, $404; and Virgin Islands $211. If only the standard deduction were assumed, food stamp benefits would drop by about $48 monthly in most of the 48 contiguous States and D.C. Maximum food stamp benefits from October 1987 through September 1988 are $228 for a family of three except in these 4 jurisdictions, where they are as follows: Alaska, $297; Hawaii, $350; Guam, $336; and Virgin Islands, $293.

[4] Except for Alaska and Hawaii, this column is based on the Census Bureau's 1987 poverty threshold for a family of three persons, $9,056, converted to a monthly rate of $755. For Alaska, this threshold was increased by 25 percent; for Hawaii, by 15 percent, following the practice of the Office of Management and Budget.

[5] In these States part of the AFDC cash payment has been designated as energy aid and is disregarded by the State in calculating food stamp benefits. Illinois disregards $18. Kansas disregards $36. Maryland disregards $59. Michigan disregards $74. New Jersey disregards $25. Ohio disregards $14. New York disregards $53, the full amount of a benefit boost enacted in 1981 ($30) and in 1985 ($23). Oregon disregards $118. Rhode Island disregards $127.85. Washington disregards $46.

[6] With respect to maximum AFDC benefit among 50 States and D.C.

Note.—Puerto Rico was deleted because it does not have a food stamp program, instead a cash nutritional assistance payment is given to recipients.

Source: Table prepared by CRS from information provided by a telephone survey of the States.

TABLE 10.—MAXIMUM AFDC BENEFITS, BY FAMILY SIZE, JANUARY 1988 [1]

State	2-person family	3-person family	4-person family	5-person family	6-person family
Alabama	$88	$118	$147	$177	$206
Alaska* [2]	692	779	866	953	1,040
Arizona [3]	233	293	353	412	472
Arkansas	162	202	238	271	302
California*	511	633	753	859	965

TABLE 10.—MAXIMUM AFDC BENEFITS, BY FAMILY SIZE, JANUARY 1988 [1]—Continued

State	2-person family	3-person family	4-person family	5-person family	6-person family
Colorado [2,4]	280	356	432	512	590
Connecticut* [5]	485	601	701	790	883
Delaware*	236	319	374	464	529
District of Columbia	298	379	463	533	627
Florida [3]	211	275	324	375	423
Georgia	220	263	310	354	385
Hawaii* [6]	429	515	601	689	780
Idaho	245	304	344	385	418
Illinois [2,7]	250	342	386	452	507
Indiana [2]	229	288	346	405	463
Iowa	322	381	443	490	545
Kansas* [8]	338	409	470	525	580
Kentucky*	179	207	259	303	342
Louisiana [9]	138	190	234	277	316
Maine [2]	310	416	522	629	736
Maryland	280	359	432	501	551
Massachusetts*	422	510	595	682	771
Michigan:					
(Washtenaw County) [10]	474	558	659	750	878
(Wayne County) [10]	444	528	629	720	848
Minnesota* [2]	437	532	621	697	773
Mississippi	96	120	144	168	192
Missouri	226	282	330	374	416
Montana [2,3]	286	359	433	507	580
Nebraska*	280	350	420	490	560
Nevada [2]	266	325	384	443	502
New Hampshire*	424	486	541	594	665
New Jersey*	322	424	488	552	616
New Mexico*	210	264	317	371	424
New York:					
(Suffolk County)* [11]	547	665	775	888	968
(New York City)* [11]	439	539	638	739	814
North Carolina	231	266	291	317	342
North Dakota* [2]	301	371	454	516	569
Ohio	253	309	382	446	497
Oklahoma [2]	240	310	384	450	514
Oregon* [2]	352	412	501	588	670
Pennsylvania [12]	315	402	490	579	655
Rhode Island* [13]	407	503	574	646	727
South Carolina	158	200	240	281	322
South Dakota*	323	366	408	450	492

TABLE 10.—MAXIMUM AFDC BENEFITS, BY FAMILY SIZE, JANUARY 1988 [1]—Continued

State	2-person family	3-person family	4-person family	5-person family	6-person family
Tennessee	122	159	194	227	262
Texas [2]	158	184	221	246	284
Utah	301	376	439	500	550
Vermont [14]	505	603	676	763	815
Virginia [15]	294	354	410	488	518
Washington	397	492	578	666	756
West Virginia [3] [16]	201	249	312	360	413
Wisconsin [17]	440	517	617	708	766
Wyoming* [3]	320	360	390	450	510
Guam*	205	265	310	341	371
Puerto Rico [18]	66	90	114	138	162
Virgin Islands	126	171	215	259	304
Median State [19]	286	359	420	490	545

* These States pay 100 percent of the need standard.

[1] Maximum benefit paid for a family of given size with zero countable income. Family members include 1 adult caretaker.

[2] Alaska, Colorado, Illinois, Indiana, Maine, Minnesota, Montana, North Dakota, Oklahoma, Oregon, and Texas also have a children-only schedule.

[3] Arizona, Florida, Montana, West Virginia and Wyoming have two payment schedules, one that includes shelter expenses and one that does not.

[4] Colorado no longer has separate payment schedules for winter months and non-winter months.

[5] Connecticut has three rent regions. Data shown are from rent region A which has the highest rents.

[6] The Hawaii figures include shelter maximums of $236.50, $264, $291.50, 319, and $352 for an AFDC family with 2 through 6 recipients, respectively.

[7] Illinois divides itself into 3 distinct areas with regard to payment schedules. Data shown are from the Cook County area, which includes Chicago.

[8] Kansas has a basic standard and a shelter standard. The shelter standard varies from area to area (i.e., from $76 monthly to $135 monthly). The shelter payment in Topeka and some of the other larger cities is $109 monthly. The figures shown include a shelter standard of $135 monthly.

[9] Louisiana has two payment schedules—one for urban areas, from which our data were taken, and one for rural areas.

[10] Michigan has varied shelter maximums. Shown are benefits for Washtenaw County (Ann Arbor) and Wayne County (Detroit).

[11] New York has payment schedules for each social service district. Shown are the Suffolk County and New York City amounts. The figures include energy payments.

[12] Pennsylvania has four regions. The figures in the table are from region 1, which has the highest benefits.

[13] Rhode Island has a winter and non-winter payment schedule. The figures in the table are from the winter schedule which lasts from November through April. The non-winter schedule lasts from May through October.

[14] Vermont has a base amount plus a shelter maximum that depends on whether the recipient is living inside or outside of Chittenden County. The largest amount paid to a recipient with no other income equals 67.9 percent of the base amount plus 67.9 percent of the shelter allowance. The shelter maximum for families living in Chittenden County is $300 per month, for those living outside Chittenden County the shelter maximum is $235 monthly.

[15] Virginia has three payment schedules. The figures shown are from area 3 which has the highest benefits.

[16] West Virginia has three payment schedules. The figures show the higher benefit levels.

[17] Wisconsin has two regions—one for urban areas, from which our data were taken, and one for rural areas.

[18] Puerto Rico pays 50 percent of need plus 50 percent of rent as paid. The figures assume rent at $20 a month. Officials estimate that $20 is the average amount allowed for rent.

[19] Among 50 States and D.C.

Source: Table prepared by the Congressional Research Service (CRS) on the basis of a telephone survey of the States.

Need and payment standards

To receive AFDC payments, a family must pass two income tests: first, a gross income test, and second, a counted ("net") income test. The gross income test is 185 percent of the State's need standard for the relevant family size; and it applies to both applicants and enrollees. This was increased by Congress from 150 percent of the need standard by Public Law 98-369 in 1984. No one with gross income that *exceeds* 185 percent of the need standard can receive AFDC. For applicants, the counted income test is 100 percent of the need standard, and it determines whether the family is deemed to be in "need" (see tables 9 and 10).

However, to be eligible for an actual payment, the family's counted income also must be below the State's payment standard, which in 29 jurisdictions is below the need standard.

Further, a $10 minimum payment rule imposed by Public Law 97-35 requires that counted income be at least $10 below the payment standard for an actual payment to be made.

Table 11 presents the change in the AFDC need standard from July 1970 to January 1988, by State. The increase in the median State from July 1970 to July 1975 (a period of 5 years) was 20 percent and from July 1975 to July 1980 it was 15 percent. From July 1980 to January 1988 (a period of 7½ years), the increase was 57 percent. Between July 1970 and January 1987, the Consumer Price Index (CPI) rose an estimated 198 percent.

Many States increased their need standards (but often not actual benefit levels) after passage of the gross income limit in 1981.

TABLE 11.—AFDC NEED STANDARD FOR A THREE-PERSON FAMILY BY STATE FOR SELECTED YEARS

	July 1970 [1]	July 1975	July 1980	January 1985 [2]	January 1987 [2]	January 1988 [2]
Alabama	$184	$180	$192	$384	$384	$384
Alaska	350	350	457	719	749	779
Arizona	212	233	233	233	621	621
Arkansas	149	245	234	234	234	695
California	351	316	480	555	617	633
Colorado	193	217	290	421	421	421
Connecticut	283	346	475	546	590	601
Delaware	245	245	266	287	310	319
District of Columbia	229	286	394	654	712	712
Florida	189	195	195	400	400	775
Georgia	177	193	193	366	366	366
Hawaii	226	428	468	468	468	515
Idaho	238	345	371	554	554	554
Illinois	232	261	288	657	689	713
Indiana	272	307	307	307	307	320
Iowa	247	309	360	497	497	497
Kansas	243	321	345	373	403	409

TABLE 11.—AFDC NEED STANDARD FOR A THREE-PERSON FAMILY BY STATE FOR SELECTED YEARS—Continued

	July 1970 [1]	July 1975	July 1980	January 1985 [2]	January 1987 [2]	January 1988 [2]
Kentucky	208	185	188	197	197	207
Louisiana	172	164	402	538	610	632
Maine	277	277	415	510	558	573
Maryland	249	259	270	433	478	497
Massachusetts	268	259	379	439	491	510
Michigan (Washtenaw County)	NA	NA	NA	592	666	666
Michigan (Wayne County)	219	333	425	557	630	630
Minnesota	256	330	417	524	532	532
Mississippi	202	241	220	286	368	368
Missouri	285	325	312	312	312	312
Montana	221	201	259	401	428	434
Nebraska	281	279	310	350	350	350
Nevada	269	279	285	285	285	550
New Hampshire	262	308	346	378	397	486
New Jersey	302	310	360	385	404	424
New Mexico	167	197	220	258	258	264
New York (Suffolk County)	NA	NA	NA	579	602	665
New York (New York City)	279	332	394	474	497	539
North Carolina	168	183	192	446	518	532
North Dakota	232	283	334	371	371	371
Ohio	207	346	346	627	673	685
Oklahoma	179	217	282	282	471	471
Oregon	229	369	282	386	397	412
Pennsylvania	265	296	332	614	614	614
Rhode Island	229	278	340	479	503	503
South Carolina	162	178	187	187	380	388
South Dakota	264	289	321	329	366	366
Tennessee	179	179	179	246	345	353
Texas	198	155	155	494	574	574
Utah	223	327	480	685	693	693
Vermont	287	402	670	852	859	889
Virginia	240	298	344	363	393	393
Washington	258	315	458	768	800	835
West Virginia	220	275	275	275	497	497
Wisconsin	214	383	522	628	641	647
Wyoming	246	240	315	360	360	360
Guam	NA	NA	261	265	265	265

TABLE 11.—AFDC NEED STANDARD FOR A THREE-PERSON FAMILY BY STATE FOR SELECTED YEARS—Continued

	July 1970[1]	July 1975	July 1980	January 1985[2]	January 1987[2]	January 1988[2]
Puerto Rico	108	108	102	180	180	180
Virgin Islands	NA	131	209	209	209	209
Median State[3]	232	279	321	401	471	503

[1] Data on 3-person families were not published or reported before 1975. Thus, the 1970 data were derived by reducing the reported 4-person need standard by the proportional difference between 3- and 4-person AFDC need standards as shown in the July 1975 DHEW reports.

[2] CRS survey data.

[3] Among 50 States and D.C.

NA—Not available.

Note: Table compiled by the Congressional Research Service (CRS) on the basis of data from the Department of Health and Human Services and, where noted, from CRS itself.

Trends

Table 12 presents information on how the maximum AFDC benefit for a 3-person family with no income has grown from July 1970 to January 1988 by State. In current dollars, the maximum benefit of the median State climbed 28 percent from July 1970–July 1975, 23 percent from July 1975–July 1980, and 25 percent from July 1980–January 1988 (a period of 7½ years).

In constant dollars (after adjustment for inflation), in all but 3 States, benefit levels failed to keep pace with inflation. The median decline in benefit levels adjusted for inflation from 1970 to 1988 was 35 percent.

These changes in maximum AFDC benefit levels are summarized in table 12 below. The median State's maximum AFDC benefit (guarantee) for a family of three rose in nominal terms from $184 in fiscal year 1970 to $359 in fiscal year 1988. In constant dollars, however, the median State's guarantee declined 35 percent.

Most AFDC families are eligible also for food stamps (until 1979 all were). As real AFDC benefits declined in the last dozen years, food stamp benefits rose to offset part of their losses. However, combined AFDC-food stamp benefits for a 3-person family without countable income on average dropped from $687 (1988 dollars) in July 1976, when food stamps operated under uniform national rules, to $555 (1988 dollars) in July 1987. This drop, which amounted to 19 percent, was almost wholly due to shrinkage in AFDC benefit levels. Food stamp maximum benefits were virtually unchanged in real terms, since they were adjusted for food price inflation in all years except 1982. See Appendix G.

TABLE 12.—AFDC MAXIMUM BENEFIT FOR A THREE-PERSON FAMILY, BY STATE FOR SELECTED YEARS

	July 1970 [1]	July 1975	July 1980	January 1985 [2]	January 1987 [2]	January 1988 [2]	Percent change in 1970–88 [3]
Alabama	$65	$108	$118	$118	$118	$118	−39
Alaska	328	350	457	719	749	779	−20
Arizona	138	163	202	233	293	293	−29
Arkansas	89	125	161	164	192	202	−24
California	186	293	473	555	617	633	14
Colorado	193	217	290	346	346	356	−38
Connecticut	283	346	475	546	590	601	−29
Delaware	160	221	266	287	310	319	−33
District of Columbia	195	243	286	327	364	379	−35
Florida	114	144	195	240	264	275	−19
Georgia	107	123	164	208	256	263	−18
Hawaii	226	428	468	468	468	515	−24
Idaho	211	300	323	304	304	304	−52
Illinois	232	261	288	341	342	342	−51
Indiana	120	200	255	256	256	288	−20
Iowa	201	294	360	360	381	381	−36
Kansas	222	321	345	373	403	409	−38
Kentucky	147	185	188	197	197	207	−53
Louisiana	88	128	152	190	190	190	−28
Maine	135	176	280	370	405	416	3
Maryland	162	200	270	313	345	359	−26
Massachusetts	268	259	379	396	491	510	−36
Michigan (Wayne County)	219	333	425	468	473	528	−19
Minnesota	256	330	417	524	532	532	−30
Mississippi	56	48	96	96	120	120	−28
Missouri	104	120	248	263	279	282	−9
Montana	202	201	259	332	354	359	−40
Nebraska	171	210	310	350	350	350	−31
Nevada	121	195	262	233	285	325	−10
New Hampshire	262	308	346	378	397	486	−38
New Jersey	302	310	360	385	404	424	−53
New Mexico	149	169	220	258	258	264	−41
New York (New York City)	279	332	394	474	497	539	−35
North Carolina	145	183	192	223	259	266	−39
North Dakota	213	283	334	371	371	371	−42
Ohio	161	204	263	290	302	309	−36
Oklahoma	152	217	282	282	310	310	−32
Oregon	184	337	282	386	397	412	−25
Pennsylvania	265	296	332	364	382	402	−49
Rhode Island	229	278	340	479	503	503	−26
South Carolina	85	96	129	187	199	200	−21
South Dakota	264	289	321	329	366	366	−54

TABLE 12.—AFDC MAXIMUM BENEFIT FOR A THREE-PERSON FAMILY, BY STATE FOR SELECTED YEARS—Continued

	July 1970 [1]	July 1975	July 1980	January 1985 [2]	January 1987 [2]	January 1988 [2]	Percent change in 1970–88 [3]
Tennessee	112	115	122	138	155	159	−52
Texas	148	116	116	167	184	184	−58
Utah	175	252	360	363	376	376	−28
Vermont	267	322	492	558	572	603	−24
Virginia	225	268	310	327	354	354	−47
Washington	258	315	458	476	492	492	−36
West Virginia	114	206	206	206	249	249	−27
Wisconsin	184	342	444	533	544	517	−6
Wyoming	213	235	315	360	360	360	−43
Guam	NA	NA	261	265	265	265	NA
Puerto Rico	43	43	44	90	90	90	−30
Virgin Islands	NA	131	209	171	171	171	NA
Median State [4]	184	235	288	332	354	359	−35

[1] Data on 3-person families were not published or reported before 1975. Thus, the 1970 data were derived by reducing the reported 4-person maximum benefit amount by the proportional difference between 3- and 4-person AFDC maximum benefit as shown in the July 1975 DHEW reports.

[2] CRS survey data.

[3] Real percentage change, calculated assuming a January 1988 CPI value of 347 relative to the average 1970 value of 116.3.

[4] Among 50 States and D.C.

NA—Not available.

Note: Table compiled by CRS on the basis of data from DHHS and, where noted, from CRS itself.

TABLE 13.—HISTORICAL TRENDS IN AVERAGE PAYMENT PER RECIPIENT AND PER FAMILY; AND MAXIMUM AND MEDIAN BENEFITS FOR A FAMILY OF FOUR; FOR SELECTED YEARS FROM 1970 TO 1987 [1]

	1970	1975	1980	1984	1985	1986	1987
AFDC payments:							
Average monthly benefit per family	178	210	274	322	339	353	360
Average monthly benefit per person	46	63	94	110	116	120	123
Median State benefit in July for a family unit of 4 with no income [1]	221	264	350	376	399	415	420
Median State benefit in July in constant 1986 dollars [2]	621	534	463	396	405	415	405
Maximum State benefit in July for a family unit of 4 with no income	375	497	563	660	800	823	833
Maximum State benefit in July in constant 1986 dollars [2]	1,054	1,004	745	695	813	823	804

[1] Among 50 States and the District of Columbia.

[2] The constant dollar numbers were calculated using the CPI–U monthly Consumer Price Index series.

Source: Family Support Administration and the Congressional Research Service.

TABLE 14.—INCOME LEVELS AT WHICH AFDC ELIGIBILITY ENDS FOR A FAMILY OF 3, BY STATE AND PERIOD OF RECEIPT, JANUARY 1987 [1] [2]

				First 4 months			After 12 months		
	185 percent of need standard	Payment standard	AFDC maximum benefit	Effective eligibility level	Eligibility level as a percent of—		Effective eligibility level	Eligibility level as a percent of—	
					Poverty level	Minimum wage		Poverty level	Minimum wage
Alabama	710	118	118	274	35	47	193	25	33
Alaska	1,441	779	779	1,218	158	210	854	111	147
Arizona	1,149	293	293	524	68	90	368	48	63
Arkansas	1,286	202	202	394	51	68	277	36	48
California	1,171	633	633	1,009	131	174	708	92	122
Colorado	779	421	356	706	92	122	496	64	85
Connecticut	1,112	601	601	964	125	166	676	88	116
Delaware	590	319	319	561	73	97	394	51	68
District of Columbia	1,317	379	379	646	84	111	454	59	78
Florida	1,434	275	275	498	65	86	350	45	60
Georgia	677	366	263	628	81	108	441	57	76
Hawaii	953	515	515	841	109	145	590	76	102
Idaho	1,025	304	304	539	70	93	379	49	65
Illinois	1,319	342	342	594	77	102	417	54	72
Indiana	592	288	288	516	67	89	363	47	63
Iowa	919	381	381	649	84	112	456	59	79
Kansas	757	409	409	689	89	119	484	63	83
Kentucky	383	207	207	383	50	66	282	37	49
Louisiana	1,169	190	190	376	49	65	265	34	46
Maine	1,060	573	416	924	120	159	648	84	112
Maryland	919	359	359	618	80	106	434	56	75
Massachusetts	944	510	510	834	108	144	585	76	101
Michigan	1,166	528	528	859	111	148	603	78	104
Minnesota	984	532	532	865	112	149	607	79	105
Mississippi	681	368	120	631	82	109	443	57	76
Missouri	577	282	282	508	66	87	357	46	61
Montana	803	359	359	618	80	106	434	56	75
Nebraska	648	350	350	605	78	104	425	55	73
Nevada	1,018	325	325	569	74	98	400	52	69
New Hampshire	899	486	486	799	104	138	561	73	97
New Jersey	784	424	424	711	92	122	499	65	86
New Mexico	488	264	264	482	62	83	339	44	58
New York	997	539	539	875	113	151	614	80	106
North Carolina	984	266	266	485	63	84	341	44	59
North Dakota	686	371	371	635	82	109	446	58	77
Ohio	1,267	309	309	546	71	94	384	50	66
Oklahoma	871	310	310	548	71	94	385	50	66
Oregon	762	412	412	694	90	119	487	63	84
Pennsylvania	1,136	402	402	679	88	117	477	62	82
Rhode Island	931	503	503	824	107	142	578	75	100

TABLE 14.—INCOME LEVELS AT WHICH AFDC ELIGIBILITY ENDS FOR A FAMILY OF 3, BY STATE AND PERIOD OF RECEIPT, JANUARY 1987 [1] [2]—Continued

	185 percent of need standard	Payment standard	AFDC maximum benefit	First 4 months			After 12 months		
				Effective eligibility level	Eligibility level as a percent of—		Effective eligibility level	Eligibility level as a percent of—	
					Poverty level	Minimum wage		Poverty level	Minimum wage
South Carolina	718	388	200	659	85	114	463	60	80
South Dakota	677	366	366	628	81	108	441	57	76
Tennessee	653	353	159	609	79	105	428	55	74
Texas	1,062	184	184	368	48	63	259	34	45
Utah	1,282	693	376	1,095	142	189	768	100	132
Vermont	1,645	603	603	966	125	166	678	88	117
Virginia	727	354	354	611	79	105	429	56	74
Washington	1,545	492	492	808	105	139	567	73	98
West Virginia	919	249	249	461	60	79	324	42	56
Wisconsin	1,197	517	517	844	109	145	592	77	102
Wyoming	666	360	360	619	80	107	435	56	75

[1] These calculations assume no child care expenses and work expenses of $75 per month. The breakevens for 5–12 months can be obtained by adding $30 to the breakeven for "After 12 months."

[2] Income level at which Medicaid eligibility ends. Because of minimum payment rule, actual AFDC benefits may end at a slightly different income level.

[3] Average of the 1982 and 1988 poverty thresholds.

Source: Committee staff calculation.

AFDC EMERGENCY ASSISTANCE

The act permits States, at their option to operate an Emergency Assistance program for needy families with children (whether or not eligible for AFDC) if the assistance is necessary to avoid the destitution of the child or to provide living arrangements in a home for the child. The statute authorizes 50 percent Federal matching for emergency assistance furnished for a period not in excess of 30 days in any 12-month period. Regulations state that Federal matching is available for emergency assistance authorized by the State during one period of 30 consecutive days in any 12 consecutive months, including payments which are to meet needs which arose before the 30-day period or are for such needs as rent which extend beyond the 30-day period.

AFDC regulations also allow States to include in their State standards of need provision for meeting "special needs" of AFDC applicants and recipients. The State plan must specify the circumstances under which payments will be made for special needs.

In fiscal year 1987, 28 jurisdictions operated an Emergency Assistance program. Table 15 presents the average monthly caseload and average monthly payments for jurisdictions participating in the program.

TABLE 15.—EMERGENCY ASSISTANCE: TOTAL CASELOAD AND PAYMENTS (FEDERAL AND STATE) FISCAL YEAR 1987—PRELIMINARY DATA

	Average monthly caseload	Average monthly payments
California [1]	665	$2,323,335
Delaware	168	25,159
District of Columbia	1,838	81,136
Georgia	1,589	616,954
Illinois	188	36,052
Kansas	143	25,046
Maine	278	81,595
Maryland	1,523	377,057
Massachusetts	5,459	2,274,135
Michigan	5,111	1,317,797
Minnesota	1,422	602,563
Montana	80	19,929
Nebraska	137	81,426
New Jersey [2]	780	740,095
New York [2]	7,676	5,489,065
North Carolina	2,621	700,821
Ohio	3,834	517,303
Oklahoma	1,358	277,950
Oregon	1,727	330,707
Pennsylvania	59	14,033
Vermont	279	34,341
Virginia	18	5,511
Washington	569	217,697
West Virginia	1,117	109,222
Wisconsin	633	131,515
Wyoming	357	82,435
Puerto Rico	759	17,216
Virgin Islands	2	754
U.S. total	40,390	16,530,848

[1] California's EA payments for July, August, and September were average of the first three quarters.

[2] New Jersey's EA payments and caseload data for July, August, and September were taken from Form SSA-3645, "Flash" Report. New York's caseload data were also taken from this form.

Source: DHHS, Family Support Administration.

FINANCING

The Federal Government pays at least 50 percent of each State's benefit payments and more than 70 percent in eleven States. Federal matching for AFDC varies from State to State, depending, within limits, on per capita income. Under matching formulas in the law, about 55 percent of each AFDC benefit dollar is paid by the Federal Government and 45 percent is paid by the States, some of which require local governments to share costs. The Federal share varies among States, ranging from 50 percent to 79.65 percent, and it is inversely related to State per capita income. The

Federal Government pays 50 percent of administrative costs in all States.

The Federal share of a State's AFDC payments is determined by the matching formula specified for Medicaid in title XIX of the Social Security Act. (States may choose an alternate formula, specified for AFDC only in title IV of the act, but none do so. Unlike the Medicaid formula, this "regular" AFDC formula places a ceiling on average benefits eligible for Federal funds.)

The Medicaid cost-sharing formula used to determine the State and Federal shares of AFDC benefit payments is as follows:

State share = State per capita income squared/national per capita income squared × 45 percent

Federal share = 100 percent—State share (with a minimum of 50 percent and a maximum of 83 percent)

For the outlying areas, Guam, Puerto Rico, and the Virgin Islands, 75 percent Federal matching is provided for AFDC benefits, but the law imposes a ceiling on Federal funds. The ceilings are as follows: Puerto Rico, $72 million; Guam, $3.3 million; and the Virgin Islands, $2.4 million.

The Federal share of benefits is shown in table 16.

TABLE 16.—FEDERAL SHARE OF THE AFDC PROGRAM,[1] FISCAL YEARS 1982 THROUGH 1989

[In percent]

State	1982–83 [2]	1984–85 [3]	1986	1987	1988	1989
Alabama	71.13	72.14	72.30	72.41	73.29	73.10
Alaska	50.00	50.00	50.00	50.00	50.00	50.00
Arizona	59.87	61.21	62.28	62.13	62.12	62.04
Arkansas	72.16	73.65	73.83	74.02	74.21	74.14
California	50.00	50.00	50.00	50.00	50.00	50.00
Colorado	52.28	50.00	50.00	50.00	50.00	50.00
Connecticut	50.00	50.00	50.00	50.00	50.00	50.00
Delaware	50.00	50.00	50.00	50.00	51.90	52.60
District of Columbia	50.00	50.00	50.00	50.00	50.00	50.00
Florida	57.92	58.41	56.16	55.54	55.39	55.18
Georgia	66.28	67.43	66.05	64.54	63.84	62.78
Guam (Federal funds limited) [4]	75.00	75.00	75.00	75.00	75.00	75.00
Hawaii	50.00	50.00	51.00	51.29	53.71	53.99
Idaho	65.43	67.28	69.36	71.08	70.47	72.71
Illinois	50.00	50.00	50.00	50.00	50.00	50.00
Indiana	56.73	59.93	62.82	62.92	63.71	63.71
Iowa	55.35	55.24	58.90	60.39	62.75	62.95
Kansas	52.50	50.67	50.00	51.39	55.20	54.93

TABLE 16.—FEDERAL SHARE OF THE AFDC PROGRAM,[1] FISCAL YEARS 1982 THROUGH 1989—Continued

[In percent]

State	1982–83 [2]	1984–85 [3]	1986	1987	1988	1989
Kentucky	67.95	70.72	70.23	70.75	72.27	72.89
Louisiana	66.85	64.65	63.81	65.77	68.26	71.07
Maine	70.63	70.63	68.86	68.07	67.08	66.68
Maryland	50.00	50.00	50.00	50.00	50.00	50.00
Massachusetts	53.56	50.13	50.00	50.00	50.00	50.00
Michigan	50.00	50.70	56.79	56.88	56.48	54.75
Minnesota	54.39	52.67	53.41	52.98	53.98	53.07
Mississippi	77.36	77.63	78.42	78.50	79.65	79.80
Missouri	60.38	61.40	60.62	59.85	59.27	59.96
Montana	65.34	64.41	66.38	67.44	69.40	70.62
Nebraska	58.12	57.13	57.11	58.06	59.73	60.37
Nevada	50.00	50.00	50.00	50.00	50.25	50.00
New Hampshire	59.41	59.45	54.92	53.28	50.00	50.00
New Jersey	50.00	50.00	50.00	50.00	50.00	50.00
New Mexico	67.19	69.39	68.94	69.68	71.52	71.54
New York	50.00	50.88	50.00	50.00	50.00	50.00
North Carolina	67.81	69.54	69.18	68.40	68.68	68.01
North Dakota	62.11	61.32	55.12	56.41	64.87	66.53
Ohio	55.10	55.44	58.30	58.27	59.10	58.98
Oklahoma	59.91	58.47	57.60	59.86	63.33	66.06
Oregon	52.81	57.12	61.54	62.47	62.11	62.44
Pennsylvania	56.78	56.04	56.72	57.28	57.35	57.42
Puerto Rico (Federal funds limited) [4]	75.00	75.00	75.00	75.00	75.00	75.00
Rhode Island	57.77	58.17	56.33	55.38	54.85	55.88
South Carolina	70.77	73.51	72.70	72.23	73.49	73.08
South Dakota	68.19	68.31	67.82	67.45	70.43	71.02
Tennessee	68.53	70.66	70.20	70.26	70.64	70.17
Texas		54.37	53.56	55.16	56.91	59.04
Utah	68.64	70.84	72.62	73.21	73.73	73.86
Vermont	68.59	69.37	67.06	67.37	66.23	63.92
Virgin Islands (Federal funds limited) [4]	75.00	75.00	75.00	75.00	75.00	75.00
Virginia	56.74	56.53	53.14	51.86	51.34	51.20

TABLE 16.—FEDERAL SHARE OF THE AFDC PROGRAM,[1] FISCAL YEARS 1982 THROUGH 1989—Continued

[In percent]

State	1982–83 [2]	1984–85 [3]	1986	1987	1988	1989
Washington	50.00	50.00	50.06	52.52	53.21	53.06
West Virginia	67.95	70.57	71.53	72.59	74.84	76.14
Wisconsin	58.02	56.87	57.54	57.58	58.98	59.31
Wyoming	50.00	50.00	50.00	54.20	57.96	62.61

[1] The Federal share of the AFDC program is calculated by the same formula used to determine the Federal share of medicaid costs except in States that elect an alternate formula or have no medicaid program. Texas chose the alternate formula until July 1, 1983. Arizona used the alternate formula until the first quarter of fiscal year 1983, when it was deemed qualified to use the medicaid formula for the first time. For Texas it was 55.75 for fiscal years 1982 and 1983.

[2] Effective Oct. 1, 1981, through Sept. 30, 1983.

[3] Effective Oct. 1, 1983, through Sept. 30, 1985.

[4] Public Law 96–272 made permanent the 75-percent matching rate for AFDC effective Oct. 1, 1979. For medicaid the matching rate remains 50 percent.

Source: Department of Health and Human Services, Family Support Administration.

FEDERAL AND STATE EXPENDITURES

In fiscal year 1987 AFDC benefits totaled $16.5 billion. Of total fiscal year 1987 benefits, $8.9 billion or 54.6 percent was paid by the Federal Government. Tables 17 and 18 present State and Federal expenditures for selected years.

Currently, 10 States require their localities to pay some portion of benefit costs. These States are:

California, Colorado, Indiana, Minnesota, Montana, New Jersey, New York, North Carolina, North Dakota, and Ohio.

Table 17 presents historical data on the amount of total Federal and State AFDC benefit payments to single-parent families (including two-parent families where one adult is incapacitated), unemployed parent families, and under the emergency assistance program. Benefit payments under current law are projected to be $16.8 billion in fiscal year 1988 and $19.3 billion by fiscal year 1993.

Table 18 presents Federal and State expenditures for AFDC in selected years. Administrative costs have risen much faster than total benefits since 1971. Administrative costs equaled 9.6 percent of 1971 benefits and are estimated to equal 13.1 percent of 1987 benefits.

Table 19 gives State-by-State fiscal year 1987 data on average monthly caseloads, benefit payments, State-local administrative costs, and administrative costs per family. Administrative costs ranged from $173 per family in Mississippi to $1,194 in the District of Columbia.

TABLE 17.—FEDERAL AND STATE AFDC BENEFIT PAYMENTS UNDER THE SINGLE PARENT, UNEMPLOYED PARENT, AND EMERGENCY ASSISTANCE PROGRAMS: FISCAL YEARS 1970 TO 1993

[In millions of dollars]

Fiscal year	Single parent [1] (1)	Unemployed parent (2)	Emergency assistance (3)	Total, columns 1, 2, and 3 [2] (4)	Child support collections [3] (5)	Total, columns 4 minus 5 [4] (6)	Column 6 expressed in 1986 constant dollars [5] (7)
1970	3,851	231	14	4,095	0	4,095	11,830
1971	4,993	412	22	5,427	0	5,427	14,901
1972	5,972	422	43	6,436	0	6,436	17,101
1973	6,459	414	38	6,912	0	6,912	17,743
1974	6,881	324	44	7,249	0	7,249	17,057
1975	7,791	362	70	8,223	0	8,223	17,275
1976	8,825	525	66	9,415	286	9,129	17,797
1977	9,420	617	70	10,107	423	9,684	17,718
1978	9,624	565	76	10,264	472	9,792	16,807
1979	9,865	522	81	10,468	597	9,871	15,363
1980	10,847	693	109	11,650	603	11,047	14,990
1981	11,769	1,075	127	12,971	671	12,300	15,134
1982	11,601	1,256	95	12,951	786	12,165	14,030
1983	12,136	1,471	121	13,727	880	12,847	14,278
1984	12,759	1,612	132	14,502	1,000	13,502	14,344
1985	13,401	1,556	157	15,114	903	14,211	14,517
1986	14,234	1,563	175	15,972	960	15,012	15,012
1987	14,792	1,516	203	16,511	1,078	15,433	15,030
1988 [6]	15,159	1,426	229	16,814	1,222	15,592	14,553
1989 [6]	15,664	1,443	246	17,353	1,352	16,001	14,342
1990 [6]	16,156	1,432	260	17,848	1,519	16,329	14,107
1991 [6]	16,659	1,445	272	18,376	1,707	16,669	13,939
1992 [6]	17,099	1,455	283	18,837	1,918	16,919	13,761
1993 [6]	17,512	1,459	290	19,261	2,156	17,105	13,599

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[1] Includes payments to two-parent families where one adult is incapacitated.

[2] Total AFDC benefits of which a portion are reimbursed by child support collections. Total may not add due to rounding.

[3] Total AFDC collections less payments to recipients.

[4] Net AFDC benefits—Gross benefits less those reimbursed by child support collections.

[5] Net AFDC benefits in constant 1986 dollars. Adjusted based on the CPI-W index. Projections of the CPI-W index for fiscal years 1988–1993 from the Administration.

[6] Administration projections under current law.

Source: Office of Financial Management, Family Support Administration.

TABLE 18.—TOTAL, FEDERAL, AND STATE AFDC EXPENDITURES: FISCAL YEARS 1970 TO 1993

[In millions of dollars]

Fiscal year	Federal share		State share		Total	
	Benefits	Administrative	Benefits	Administrative	Benefits	Administrative
1970	2,187	[1] 572	1,443	186	4,082	[1] 881
1971	3,008	271	2,469	254	5,477	525
1972	3,612	[2] 240	2,942	241	6,554	NA
1973	3,865	313	3,138	296	7,003	610
1974	4,071	379	3,300	362	7,371	740
1975	4,625	552	3,787	529	8,412	1,082
1976	5,258	541	4,418	527	9,676	1,069
1977	5,626	595	4,762	583	10,388	1,177
1978	5,701	631	4,890	617	10,591	1,248
1979	5,825	683	4,954	668	10,779	1,350
1980	6,448	750	5,508	729	11,956	1,479
1981	6,928	835	5,917	814	12,845	1,648
1982	6,922	878	5,934	878	12,857	1,756
1983	7,332	915	6,275	915	13,607	1,830
1984	7,707	876	6,664	822	14,371	1,698
1985	8,019	890	6,938	889	14,957	1,779
1986	8,543	993	7,254	967	15,797	1,960
1987 [3]	8,906	1,081	7,402	1,051	16,308	2,132
1988 [3]	9,082	1,134	7,503	1,097	16,585	2,231
1989 [3]	9,378	1,186	7,729	1,143	17,107	2,329
1990 [3]	9,642	1,221	7,946	1,184	17,588	2,405
1991 [3]	9,924	1,253	8,180	1,221	18,104	2,474
1992 [3]	10,171	1,281	8,383	1,254	18,554	2,535
1993 [3]	10,400	1,303	8,572	1,281	18,972	2,584

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[1] Includes expenditures for services.

[2] Administrative expenditures only.

[3] Administration projection under current law.

Note.—Benefits do not include emergency assistance payments or reimbursement from child support enforcement collections. Foster care payments are included from 1971 to 1980. Beginning in fiscal year 1984, the costs of certifying AFDC households for food stamps are shown in the food stamp appropriation, U.S. Department of Agriculture. Administrative figures include training expenditures.

NA—Not available.

Source: Office of Financial Management, Family Support Administration.

TABLE 19.—AVERAGE MONTHLY NUMBER OF AFDC FAMILIES AND RECIPIENTS, TOTAL BENEFIT PAYMENTS AND ADMINISTRATIVE COSTS, AND AVERAGE PAYMENT PER FAMILY AND PERSON, FISCAL YEAR 1987 (PRELIMINARY DATA) [1]

State	Total assistance payments (millions)	Average monthly caseload (thousands)	Average monthly recipients (thousands)	Average payment per		Total administrative costs (in millions) [2]	Annual administrative cost per AFDC family
				Family	Person		
Alabama	64.8	47,231	137,427	$114	$39	$18.1	$383
Alaska	51.0	7,446	18,617	571	228	6.4	855
Arizona	93.9	29,298	84,626	267	92	10.7	366
Arkansas	49.8	22,786	66,831	182	62	8.5	372
California	3,880.5	584,842	1,702,743	553	190	325.1	556
Colorado	117.5	31,437	90,417	311	108	19.2	611
Connecticut	221.0	38,661	111,939	476	165	21.3	550
Delaware	24.2	7,827	20,634	258	98	5.1	648
District of Columbia	77.7	19,825	52,883	327	122	23.7	1,194
Florida	291.7	103,698	290,952	234	84	65.2	628
Georgia	243.8	86,335	246,270	235	83	46.6	540
Guam	3.6	1,382	4,952	216	60	.3	207
Hawaii	68.4	14,108	42,972	404	133	7.4	526
Idaho	20.2	6,480	17,602	259	95	5.6	863
Illinois	872.9	236,557	720,848	308	101	78.3	331
Indiana	146.2	52,920	152,044	230	80	31.1	587
Iowa	166.4	39,704	114,711	349	121	12.9	324
Kansas	96.4	24,793	73,171	324	110	10.2	412
Kentucky	137.6	59,536	159,370	193	72	19.5	328
Louisiana	172.8	86,155	259,883	167	55	24.9	288
Maine	82.4	19,260	55,590	357	124	6.4	333
Maryland	250.3	66,393	182,784	314	114	35.7	538
Massachusetts	515.3	87,716	235,047	490	183	74.9	854
Michigan	1,206.0	214,410	652,076	467	153	144.3	673
Minnesota	334.4	54,554	162,355	511	172	27.8	509
Mississippi	80.7	58,017	174,578	116	39	10.0	173
Missouri	212.7	67,286	203,165	263	87	25.3	377
Montana	40.4	9,484	27,921	355	121	3.9	416
Nebraska	60.4	15,951	46,880	316	107	9.5	594
Nevada	16.3	5,727	16,613	237	82	3.8	667
New Hampshire	18.1	4,329	11,318	348	133	3.7	859
New Jersey	486.7	115,100	338,547	352	120	97.3	846
New Mexico	55.9	19,708	56,513	236	82	12.7	643
New York	2,097.9	355,497	1,062,379	492	165	372.7	1,048
North Carolina	191.0	67,529	175,310	236	91	36.5	541
North Dakota	20.9	5,060	13,989	344	125	3.4	680
Ohio	810.6	227,066	667,447	297	101	70.6	311
Oklahoma	111.5	33,423	96,631	278	96	30.6	915
Oregon	119.1	30,157	81,585	329	122	31.7	1,051
Pennsylvania	750.9	186,522	562,769	335	111	128.9	691

TABLE 19.—AVERAGE MONTHLY NUMBER OF AFDC FAMILIES AND RECIPIENTS, TOTAL BENEFIT PAYMENTS AND ADMINISTRATIVE COSTS, AND AVERAGE PAYMENT PER FAMILY AND PERSON, FISCAL YEAR 1987 (PRELIMINARY DATA) [1]—Continued

State	Total assistance payments (millions)	Average monthly caseload (thousands)	Average monthly recipients (thousands)	Average payment per		Total administrative costs (in millions) [2]	Annual administrative cost per AFDC family
				Family	Person		
Puerto Rico	66.4	54,489	177,921	102	31	14.1	260
Rhode Island	80.9	15,751	43,556	428	155	7.1	448
South Carolina	102.7	45,409	129,261	188	66	19.9	438
South Dakota	21.2	6,600	18,694	268	95	3.7	561
Tennessee	117.0	65,721	179,765	148	54	20.6	313
Texas	319.5	157,329	473,369	169	56	51.5	328
Utah	60.3	14,646	43,315	344	116	13.2	901
Vermont	41.2	7,568	21,653	454	159	5.3	706
Virgin Islands	2.9	1,120	3,975	215	61	.4	395
Virginia	173.3	56,721	149,525	255	97	44.7	787
Washington	399.5	75,478	211,734	441	157	46.9	621
West Virginia	109.9	36,955	114,552	248	80	9.4	254
Wisconsin	568.7	96,146	292,692	493	162	21.1	220
Wyoming	18.1	4,760	11,658	316	129	2.7	567
U.S. total	16,338.6	3,782,900	11,064,060	360	123	2,130.4	563

[1] Assistance Payments and Caseload data for July, August, and September for California and New Jersey were taken from Form SSA-3645, "Flash" Report. Guam's assistance payments were taken from this report and New York's caseload data were also taken from this report.

[2] Administrative costs include Other State and Local expenditures, Work Program expenditures, ADP expenditures, Training and FAMIS. Fourth quarter administrative cost data for California, Guam, New Jersey and Virginia were averages based on the prior three quarters.

Source: Office of Family Assistance, Family Support Administration, January 1988.

The 1987 CASELOAD AND RECENT TRENDS

Tables 19, 20 and 7 present recent caseload and benefits data.

Average benefits per AFDC family (2.9 persons) were $360 in fiscal year 1987, compared with $352 a year earlier. Average benefits per AFDC-UP family (4.4 persons) were $531, compared with $507 a year earlier.

Table 20 presents the average monthly number of families and individuals receiving AFDC benefits since 1970. In fiscal year 1987 AFDC family enrollment was 3.8 million. This includes 11.1 million recipients of whom approximately 67 percent were children. Of these AFDC families 236,000 were two-parent families eligible because of an unemployed parent.

TABLE 20.—HISTORICAL TRENDS IN AFDC ENROLLMENTS AND AVERAGE PAYMENTS

Fiscal year	Average monthly number of (in thousands)					Average monthly benefit	
	Families [1]	Recipients [1]	Children [1]	Unemployed parent families	Unemployed parent recipients	Family	Recipient
1970	1,909	7,429	5,494	78	420	$178	$46
1971	2,532	9,556	6,963	143	726	180	48
1972	2,918	10,632	7,698	134	639	187	51
1973	3,123	11,038	7,965	120	557	187	53
1974	3,170	10,845	7,824	95	434	194	57
1975	3,342	11,067	7,928	101	451	210	63
1976	3,561	11,339	8,156	135	593	226	71
1977	3,575	11,108	7,818	149	659	242	78
1978	3,528	10,663	7,475	127	567	250	83
1979	3,493	10,311	7,193	113	504	257	87
1980	3,642	10,597	7,320	141	612	274	94
1981	3,871	11,160	7,615	209	881	277	96
1982	3,569	10,431	6,975	232	976	300	103
1983	3,651	10,659	7,051	272	1,144	311	106
1984	3,725	10,866	7,153	287	1,222	322	110
1985	3,692	10,813	7,165	261	1,131	339	116
1986	3,747	10,995	7,294	253	1,101	352	120
1987 [3]	3,783	11,064	7,378	236	1,035	360	123
1988 [2]	3,771	11,002	NA	217	962	366	126
1989 [2]	3,802	10,079	NA	215	957	375	129
1990 [2]	3,825	11,124	NA	208	928	383	132
1991 [2]	3,861	11,204	NA	206	913	391	135
1992 [2]	3,892	11,268	NA	204	894	397	137
1993 [2]	3,925	11,343	NA	202	876	403	139

[1] Includes unemployed parent families and, for 1971–81, foster care children.

[2] Projection under current law.

[3] Preliminary data.

Source: Office of Family Assistance and Office of Financial Management, Family Support Administration.

The number of AFDC *families* rose more than 50 percent from 1971 to 1981, reaching a high of 3.9 million (monthly average) in 1981. In 1982, after OBRA took effect, the number dropped 8 percent, but in 1983 it rose 2.3 percent. Enrollment in 1987 is still slightly below that of 1981.

CHARACTERISTICS OF AFDC FAMILIES

This section describes the characteristics of AFDC families, using two main sources of data. For years through 1979, the sources were individual surveys of similar design specially conducted to gather information from agency case files. For 1982 and later years, data were derived from information collected from cases within the National Integrated Quality Control System's (NIQCS) monthly sample of cases.

As noted before, Congress changed AFDC rules significantly in 1981. The new rules primarily affected families with earnings and children living with their stepparents. For most such families, benefits were ended or reduced. In 1984, Congress again revised the AFDC program rules, restoring eligibility to some of the families affected by the 1981 changes.

Table 21 shows that the share of AFDC families with earnings fell more than 40 percent from March 1979 to 1986, from 12.8 percent to 7.5 percent. The share of families with no reported income other than AFDC climbed from 80.6 percent in 1979 to 87.8 percent in 1984, and fell to 81.3 percent by 1986. Moreover (table 23), the average amount of support contributed by stepparents (and in 1982 and thereafter deemed from them) more than doubled, from $63 per family in March 1979 to $153 in 1986.

Table 21 also shows the trend in other selected characteristics of AFDC families from 1969 to 1986. During this period, the average family size decreased from 4.0 persons to 3.0, the percent of families participating in the food stamp program increased, and the share of AFDC households with nonrecipient members climbed.

Among the 1984 changes made by Congress is the provision which for the first time establishes a standard definition of the AFDC assistance unit. Under this new policy, the parent(s) in the home and all minor related children must be included in the AFDC unit except SSI recipients. According to the 1986 quality control data, 37 percent of the total AFDC caseload lives with others who are not part of the AFDC unit. Some of these families were affected by the standard filing unit provision enacted in 1984. According to May 1982 quality control data:

—Most of the mothers who had been excluded from the AFDC unit but were collecting AFDC for their children were 21 years of age or older (79 percent). Only 16 percent of the mothers who had excluded themselves from the AFDC unit were under the age of 20.

—Most of the mothers who were living with their children but excluded from the AFDC unit were living with other relatives. These relatives could be grandparents, siblings, or other relatives of the AFDC children. Only 6 percent of the mothers were living with nonrelatives.

—The 212,000 cases where the mother was in the home but excluded from the AFDC unit were distributed as follows: (1) in 5 percent of the cases another adult was included in the AFDC unit; (2) in 93 percent of the cases, only children formed the AFDC unit. These children lived with other adults (64,000 cases), other adults and children (37,000 cases), stepparents (36,000), or adults who were receiving SSI (62,000 cases).

—In 1.038 million cases the mother was included in the AFDC unit but the family was living with other people. These cases are distributed as follows: (1) in 516,000 cases the persons outside the AFDC unit were adults; (2) in 254,000 cases adults and children were in the household but not in the assistance unit; (3) in 142,000 cases children were the only other persons in the household who were not receiving AFDC; (4) in 85,000 cases the adults and children who had been excluded from the AFDC unit were receiving SSI; and (5) in 42,000 cases, the persons outside the AFDC unit were stepparents.

—The cases in which only children had been excluded from the unit or in which a parent and child(ren) had been excluded were far more likely to be located in the South. For example, 44.6 percent of the cases adding a child to the unit were in the South but only 26.2 percent of the total caseload lived in the South.

Table 21 indicates that the share of AFDC families with no more than two children rose from 49.6 percent in 1969 to 73.5 percent in 1986. The share of AFDC families with a mother (or other caretaker relative) younger than 20 declined from 1975 to 1986, and the percentage of families reporting no father in the home rose from 84.7 percent in 1979 to 91.2 percent in 1986.

TABLE 21.—AFDC CHARACTERISTICS, 1969–86

	May 1969	January 1973	May 1975	March 1979	1983 [1]	1984 [1]	1986 [1]
Average family size (persons)	4.0	3.6	3.2	3.0	3.0	2.9	3.0
Number of child recipients (percent of AFDC cases):							
One	26.6	NA	37.9	42.3	43.4	44.1	42.7
Two	23.0	NA	26.0	28.1	29.8	29.6	30.8
Three	17.7	NA	16.1	15.6	15.2	15.5	15.9
Four or more	32.5	NA	20.0	13.9	10.1	10.0	9.8
Unknown		NA			1.5	0.8	0.8
Basis for eligibility (percent children):							
Parents present:							
Incapacitated	[2] 11.7	10.2	7.7	5.3	3.4	3.6	2.8
Unemployed	[2] 4.6	4.1	3.7	4.1	9.2	8.6	6.2
Parents absent:							
Death	[2] 5.5	5.0	3.7	2.2	1.9	1.9	1.7
Divorce or separation	[2] 43.3	46.5	48.3	44.7	38.6	36.2	31.7
No marriage tie	[2] 27.9	31.5	31.0	37.8	45.5	46.4	52.6
Other reason	[2] 3.5	3.6	4.0	5.9	1.4	1.2	2.5
Education of mother (percent of mothers): [3]							
8th Grade or less	29.4	NA	16.7	9.5	NA	NA	4.8
1–3 years of HS	30.7	NA	31.7	20.8	NA	NA	14.3
High School Degree	16.0	NA	23.7	18.8	NA	NA	17.3
Some College	2.0	NA	3.9	2.7	NA	NA	3.4
College Graduate	0.2	NA	0.7	0.4	NA	NA	0.5
Unknown	21.6	NA	23.3	47.8	NA	NA	59.7
Age of mother (percent of mothers):							
Under 20	6.6	NA	8.3	[4] 4.1	[4] 3.6	NA	[4] 3.3
20 to 24	16.7	NA	(5)	[6] 28.0	[6] 28.6	NA	[7] 33.6

TABLE 21.—AFDC CHARACTERISTICS, 1969–86—Continued

	May 1969	January 1973	May 1975	March 1979	1983 [1]	1984 [1]	1986 [1]
25 to 29	17.6	NA	(5)	[8] 21.4	[8] 23.8	NA	[9] 20.0
30 to 39	30.4	NA	27.9	[8] 27.2	[8] 27.9	NA	[8] 30.1
40 or over	25.0	NA	17.6	[8] 15.4	[8] 15.7	NA	[8] 13.0
Unknown	3.6	NA	3.0	[8] 4.0	[8] 0.3	NA	0
Ages of children (percent of recipient children):							
Under 3	14.9	NA	16.5	18.9	22.5	21.6	21.9
3 to 5	17.6	NA	18.1	17.5	20.1	21.0	21.1
6 to 11	36.5	NA	33.7	33.0	31.5	31.9	32.4
12 and over	31.0	NA	30.9	29.8	25.5	25.5	24.3
Unknown		NA	0.8	0.9	0.3	0.2	0.1
Mother's employment status (percent):							
Full-time job	8.2	9.8	10.4	8.7	1.5	1.2	1.6
Part-time job	6.3	6.3	5.7	5.4	3.4	3.6	4.2
Presence of income (percent families):							
With earnings	NA	16.3	14.6	12.8	5.7	6.0	7.5
No non-AFDC income	56.0	66.9	71.1	[10] 80.6	[10] 86.8	[10] 87.8	[10] 81.3
Median months on AFDC since most recent opening	23.0	27.0	31.0	29.0	26.0	26.0	27.0
Race (percent parents) [11]							
White	NA	38.0	39.9	40.4	41.8	41.3	39.7
Black	45.2	45.8	44.3	43.1	43.8	41.9	40.7
Hispanic	NA	13.4	12.2	13.6	12.0	12.8	14.4
Native American	1.3	1.1	1.1	1.4	1.0	1.1	1.3
Asian	NA	NA	0.5	1.0	1.5	2.3	2.3
Other and unknown	4.8	1.7	2.0	.4	NA	0.6	1.4
Incidence of households (percent):							
Living in public housing	12.8	13.6	14.6	NA	10.0	10.1	9.6
Participating in food stamp or donated food program	52.9	68.4	75.1	75.1	83.0	80.1	80.7
Including nonrecipient members	33.1	34.9	34.8	NA	36.9	36.9	36.7
Father's relationship to youngest child (percent):							
No father	NA	NA	NA	84.7	89.8	89.8	91.2
Natural father	NA	NA	NA	9.6	NA	NA	NA
Adoptive father	NA	NA	NA	0.0	NA	NA	NA
Stepfather	NA	NA	NA	5.6	NA	NA	NA

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[1] Data are for the Federal fiscal year October through September. All percentages are based on the average monthly caseload during the year. Hawaii and the territories are not included in 1983. Territories are not included in 1984 and 1986.

[2] Calculated on the basis of total number of families.

[3] For 1986, education is for all AFDC adult recipients.

[4] Under age 19. Includes other caretaker adult if mother absent.

[5] The percentage for 20 to 29 year olds was 43.1.

[6] Ages 19–24. Includes other caretaker adult if mother absent.

[7] Ages 19–25 in 1986. Includes other caretaker if mother absent.

[8] Includes other caretaker adult if mother absent.

[9] Ages 26–29 in 1986. Includes other caretaker if mother absent.

[10] State collected child support directly beginning in 1975, removing one source of non-AFDC income.

[11] For 1983, 12.6 percentage points where race was unknown were allocated proportionately across all categories. For 1984, 3.6 percent unknown were distributed proportionately within States reporting large proportions of unknown.

NA Not available.

Source: Office of Family Assistance, Family Support Administration and Congressional Budget Office.

Table 22 presents data about the employment status of the AFDC mother (or other caretaker relative), information about her status with the work incentive program (WIN), and data about tenure on AFDC.

The table indicates that the share of mothers (or other caretaker relatives) working full time declined from 8 percent in 1979 to 1.6 percent in 1986; the share working part-time fell from 5.0 percent to 4.2 percent in the same period.

The table also indicates that the share of families who received benefits for more than 5 years (since the most recent opening of their case) declined slightly from 26.9 percent in 1979 to 25.9 percent in 1986.

TABLE 22.—EMPLOYMENT AND WIN STATUS OF AFDC MOTHERS, TENURE OF AFDC FAMILIES, MARCH 1979, MAY 1982, FISCAL YEARS 1983, 1984, AND 1986 [1]

	Percent of total caseload				
	March 1979 [2]	May 1982 [3]	1983 [4]	1984 [4]	1986 [4]
WIN status of mother (or other caretaker):					
No mother or (caretaker) mother not receiving payment	18.0	12.2	8.7	...	...
Mandatory registrant	20.6	25.9	28.8	30.3	36.3
Voluntary registrant	4.1	1.6	1.8	2.5	2.3
Ill or incapacitated	4.1	3.0	3.8	3.2	3.4
Child or other care	43.1	40.6	43.0	51.4	46.5
No WIN project	7.2	10.5	NA	NA	NA
Other	2.9	6.2	10.8	10.7	8.4
Unknown	NA	NA	3.2	2.0	3.1
Employment status of mother (or other caretaker):					
No mother (caretaker)	8.3	12.2	8.7	...	...
Full-time work, 35 or more hours per week	8.0	1.3	[5] 1.5	[5] 1.2	[5] 1.6
Part-time work, fewer than 35 hours per week	5.0	4.3	[5] 3.4	[5] 3.7	[5] 4.2
Incapacitated	6.0	NA	4.1	3.3	3.4
At school	2.6	NA	2.0	1.7	1.9
On layoff	0.5	NA	0.8	0.4	0.2
Seeking work	9.1	NA	NA	21.8	27.3
Other—needed at home or not actively seeking work	60.5	82.2	79.5	64.8	58.3

TABLE 22.—EMPLOYMENT AND WIN STATUS OF AFDC MOTHERS, TENURE OF AFDC FAMILIES, MARCH 1979, MAY 1982, FISCAL YEARS 1983, 1984, AND 1986 [1]—Continued

	Percent of total caseload				
	March 1979 [2]	May 1982 [3]	1983 [4]	1984 [4]	1986 [4]
Number of months on AFDC since most recent opening (percent of cases):					
1 to 6 months	16.4	20.0	18.9	18.1	17.2
7 to 12 months	12.5	12.4	13.1	12.8	12.6
13 to 24 months	16.7	16.2	16.6	17.8	17.2
25 to 36 months	11.4	12.6	12.0	11.4	11.8
37 to 60 months	15.3	14.2	15.4	16.2	14.9
61 plus months	26.9	23.5	23.7	23.4	25.9
Unknown	0.8	1.1	0.3	0.1	0.4

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[1] See text about difference in data sources for 1979 and 1982.

[2] Source: Committee staff tabulation of March 1979 AFDC recipients' data base.

[3] Source: Office of Family Assistance, FSA.

[4] Fiscal year average monthly. 1983 does not include Hawaii or the territories. 1984 and 1986 data do not include the territories.

[5] Full-time work, 30 hours or more per week; part-time work, fewer than 30 hours per week.

NA=Not available.

Table 23 presents data on income sources of AFDC families. It indicates that the share of AFDC families with earnings from the mother (or other caretaker relative) or from the spouse of the caretaker relative declined from 12.0 percent in March 1979 to 6.2 percent in 1986. Further, according to the table, the average amount earned dropped in nominal terms from $382 to $264 for mothers with earnings; and from $323 to $271 for fathers (or spouses of caretaker relatives) with earnings.

TABLE 23.—INCOME SOURCES OF AFDC FAMILIES,[1] MARCH 1979,[2] MAY 1982,[3] FISCAL YEARS 1984 AND 1986

Income source	Percentage of caseload with income type				Average amount for those with income type			
	March 1979	May 1982	1984	1986 [4]	March 1979	May 1982	1984 [4]	1986 [4]
Earned income:								
Mother (or caretaker relative)	12.0	5.3	5.2	6.2	$382	$261	$245	$264
Father (or spouse of caretaker relative)	0.6	0.4	0.6	1.0	323	244	270	271
Children (14+)	0.1	([5])	0.2	0.3	206	398	237	323
Other adults	0.1	NA	NA	0.2	265	NA	NA	420
Public service	0.1	NA	NA	NA	246	NA	NA	NA
OASDI	3.1	2.5	1.9	2.0	134	145	201	207
Veterans' benefits	0.4	NA	NA	0.2	128	NA	NA	139
Other government income	0.4	0.4	0.4	0.3	143	134	217	131

TABLE 23.—INCOME SOURCES OF AFDC FAMILIES,[1] MARCH 1979,[2] MAY 1982,[3] FISCAL YEARS 1984 AND 1986—Continued

Income source	Percentage of caseload with income type				Average amount for those with income type			
	March 1979	May 1982	1984	1986 [4]	March 1979	May 1982	1984 [4]	1986 [4]
Unemployment compensation..	0.7	1.0	0.7	0.7	238	255	290	289
Workmen's compensation........	0.1	(4)	NA	0.1	237	200	NA	299
Deemed income........................	0.2	0.3	NA	0.1	63	159	NA	153
Contributions from other persons..............................	0.6	0.9	NA	NA	72	79	NA	NA
Other cash income..................	1.9	2.5	[6] 2.9	[6] 2.0	81	251	103	128
In-kind income........................	0.4	NA	NA	NA	71	NA	NA	NA
Total..........................	19.4	NA	12.2	18.7	299	NA	225	228

[1] See text about differences in data sources for 1979 and 1982.

[2] Source: Committee staff tabulation of March 1979 AFDC recipients' data base.

[3] Source: Office of Family Assistance, FSA.

[4] Fiscal year average monthly. 1984 and 1986 data do not include the territories.

[5] Less than 0.05 percent.

[6] Includes Federal SSI, State SSI, general assistance, income from assets and property and other unearned income.

NA—Not available.

Table 24 provides data on the share of AFDC families whose benefits were based on less than their gross cash income. That is, it summarizes information about disregarded (uncounted) income.

The table shows a decline in the share of families receiving the work incentive disregard (exclusion of the first $30 earned monthly plus one-third of the rest of earnings). This work incentive bonus was repealed in 1981, except for the first 4 months of a job. It indicates that the average amount of child care costs disregarded declined from $101 monthly in March 1979 (for those with such costs) to $86 in May 1982, increased to $93 in 1984, and increased to $106 in 1986.

TABLE 24.—INCOME OF AFDC FAMILIES NOT COUNTED BY THE PROGRAM,[1] MARCH 1979,[2] MAY 1982,[3] FISCAL YEARS 1984 [4] AND 1986

Disregards	Percent of caseload with disregard				Average amount for those with disregard			
	March 1979	May 1982	1984	1986	March 1979	May 1982	1984	1986
Optional $5 disregard................	1.1	(5)	(5)	(5)	$6	(5)	(5)	(5)
$30 and one-third of earned income..................................	12.5	[6] 2.5	2.1	3.8	147	[6] $62	$90	[7] $76
Child care..................................	3.9	1.3	1.0	1.5	101	86	93	106
Other work expenses.................	8.4	5.2	4.9	6.2	95	54	60	76
Cases with child care and other work expenses [8]..........	3.0	....	....	....	100	....	....	....

TABLE 24.—INCOME OF AFDC FAMILIES NOT COUNTED BY THE PROGRAM,[1] MARCH 1979,[2] MAY 1982,[3] FISCAL YEARS 1984[4] AND 1986—Continued

Disregards	Percent of caseload with disregard				Average amount for those with disregard			
	March 1979	May 1982	1984	1986	March 1979	May 1982	1984	1986
Child support	0.1	(9)	NA	3.0	93	NA	NA	[10] 47
Other	1.6	0.4	NA	NA	77	100	NA	NA
Total	13.8	NA	5.0	6.3	250	NA	116	146

[1] See text about differences in data sources for March 1979 and May 1982.

[2] Source: Committee staff tabulation of March 1979 AFDC recipients' data base.

[3] Source: Office of Family Assistance, FSA.

[4] Average monthly for fiscal years.

[5] Repealed by 1981 law.

[6] Limited to 4 months' duration by 1981 law.

[7] $30 disregard extended for 8 months after end of $30 plus one-third by 1984 law.

[8] In these cases, there was insufficient information in the data file to distinguish between child care and other work expenses.

[9] Less than 0.05 percent.

[10] Average amount of $50 child support passthrough.

NA—Not available.

The AFDC recipient population is not a homogenous group of families or individuals, as illustrated in table 25. The table subdivides the AFDC caseload into seven mutually exclusive and exhaustive groups. Column one of the table contains data on the entire caseload. Column two of the table describes the AFDC units with no adult recipients. They represent 9.4 percent of the AFDC units and 6.5 percent of total payments. In 1979, they received 9.5 percent of the total payments. The average payment per case is $244 per month.

Columns 3–6 represent characteristics of the more typical AFDC units—one adult with children. The one adult caseload was split into four groups based on the reason for deprivation of the youngest child. Column three are those cases with one adult and the reason for AFDC eligibility is that the other adult is absent because they are not married; these represent 48.1 percent of AFDC units.

The final two columns (columns seven and eight) of the table present characteristics of cases with two adult recipients. Column eight represents those cases where one parent is incapacitated, and column seven presents data on the unemployed parents (AFDC–UP) program caseload. In total, they represent about 8.2 percent of the total caseload and receive about 11.6 percent of the total payments. The cases where one parent is incapacitated tend to be older, as demonstrated by both the age of the mother and the age of the youngest child.

TABLE 25.—1986 AFDC CHARACTERISTICS

	Total	No adult	One adult: Not married	One adult: Divorced or legally separated	One adult: Not legally separated or divorced	One adult: Other reasons	Two adult: Unemployed parent	Two adult: Other
Number of families (in thousands) [1]	3,681	345	1,771	543	497	222	217	86
Percent of total	100.0	9.4	48.1	14.8	13.5	6.0	5.9	2.3
Average monthly payment	$350	$244	$339	$362	$366	$354	$517	$434
Percent of total payments	100.0	6.5	46.5	15.2	14.1	6.1	8.7	2.9
Average number in assistance unit	2.9	1.7	2.9	3.0	3.2	2.7	4.5	4.3
Food Stamps:								
Percent participating	82.7	54.8	84.4	86.8	88.5	83.6	94.7	94.1
	Percentage Distributions							
Number of recipients:								
One	6.5	57.0	0.0	0.0	0.0	18.7	0.0	0.0
Two	37.8	27.6	47.9	38.1	31.9	34.2	0.0	7.0
Three	28.0	9.7	28.3	37.0	34.5	24.0	22.7	25.4
Four	16.4	3.8	14.7	17.1	20.7	13.6	36.4	28.3
Five	7.0	1.1	5.8	5.7	8.0	6.0	22.4	21.2
Six	2.8	0.5	2.1	1.6	3.2	2.2	11.3	11.0
Seven or more	1.5	0.3	1.1	4.0	1.6	1.2	7.3	7.0
Number of nonrecipients:								
Zero	63.1	1.8	66.7	72.1	73.4	53.6	86.9	84.6
One	15.8	39.9	12.6	14.7	12.4	25.6	6.9	9.8
Two	8.7	23.9	7.8	7.3	6.7	8.5	3.0	2.6
Three or more	12.3	34.4	12.9	5.9	7.5	12.3	3.2	3.1
Shelter:								
Owns or buying	5.1	7.7	1.9	8.9	4.5	6.6	13.8	13.3
Public housing	10.0	7.6	12.3	8.1	8.7	9.1	4.8	8.3
HUD rent subsidy	9.5	4.7	11.0	11.6	8.4	6.5	6.6	5.3
Other subsidy	1.6	1.0	1.7	2.2	1.3	1.7	1.1	2.8
Private housing	66.3	66.6	64.7	64.3	69.7	70.1	71.9	68.7
Rents free	2.0	2.0	2.4	1.5	2.2	1.5	0.3	0.8
Group quarters	5.5	10.6	6.0	3.4	5.2	4.5	1.5	2.8
Number of child recipients:								
Zero or one	43.4	57.0	48.0	38.3	32.4	44.8	23.4	35.5
Two	30.8	27.7	28.4	36.9	34.4	28.3	36.5	26.3
Three	16.0	9.6	14.6	17.2	20.5	15.9	22.1	20.7
Four or more	9.8	5.7	8.9	7.6	12.7	11.1	18.0	17.5
Race of caretaker: [1]								
White	40.2	28.6	28.0	70.5	42.5	41.8	66.4	61.5
Black	41.5	44.5	57.4	16.4	33.8	30.9	8.9	15.7
Asian or Hispanic	17.0	25.0	13.3	11.9	22.5	25.6	23.6	21.8
American Indian	1.3	1.9	1.3	1.3	1.3	1.6	0.9	1.1
Age of youngest child in AFDC unit: [1]								
Under 3	38.4	22.8	47.2	14.3	35.5	47.5	49.6	42.1
3 to 5	22.7	17.3	24.2	24.0	24.0	14.6	22.3	17.9
6 to 11	24.3	30.4	20.2	36.6	25.6	20.7	18.3	22.3
12 to 15	10.7	20.1	6.5	18.7	11.0	12.1	7.5	11.5
16 to 18	3.8	9.4	1.8	6.4	3.8	5.2	2.1	6.2

TABLE 25.—1986 AFDC CHARACTERISTICS—Continued

	Total	No adult	One adult: Not married	One adult: Divorced or legally separated	One adult: Not legally separated or divorced	One adult: Other reasons	Two adult: Unemployed parent	Two adult: Other
Number of months continuously on AFDC								
6 or less	17.2	15.0	13.6	18.0	22.0	25.9	25.3	25.5
7 to 12	12.7	11.3	12.0	13.7	14.8	11.0	14.5	14.2
13 to 18	9.7	9.7	9.5	10.7	9.9	6.5	10.1	12.5
19 to 24	7.6	7.3	7.5	8.2	7.9	6.7	8.6	4.7
25 to 36	11.9	11.0	12.4	12.3	11.4	9.4	12.8	9.7
37 to 48	8.8	9.2	9.1	9.6	8.0	8.0	8.0	6.6
49 to 60	6.1	5.8	6.5	5.8	5.3	5.9	6.9	6.8
61 to 120	18.0	18.9	20.2	16.1	14.3	18.5	12.1	15.8
121 to 180	5.5	8.1	6.2	4.5	4.6	5.6	1.2	2.8
181 and up	2.4	3.6	2.9	1.3	1.9	2.5	0.4	1.3
Age of female adult recipient: [1]								
11 to 18	3.1	NA	4.2	0.4	1.3	5.4	2.6	1.4
19 to 21	12.7	NA	16.8	3.8	8.2	15.0	10.6	6.0
22 to 25	21.1	NA	24.7	14.0	18.4	16.6	21.4	15.2
26 to 29	20.2	NA	20.2	20.9	21.1	15.6	20.6	18.5
30 to 34	18.3	NA	16.1	25.7	20.0	12.8	19.5	17.9
35 to 39	12.0	NA	9.2	18.8	14.5	11.3	12.2	16.9
40 and up	12.7	NA	8.7	16.3	16.4	23.3	13.2	24.0
AFDC female adults employment status: [1]								
Employed part-time	1.6	NA	1.2	2.9	2.0	1.1	1.1	1.4
Employed full-time	4.2	NA	3.3	7.2	3.8	3.2	5.4	3.8
Employed other	0.1	NA	0.1	0.3	0.1	0.1	0.2	0.5
Not employed	65.8	NA	69.7	51.7	63.5	70.8	68.7	68.7
Unemployed	28.3	NA	25.6	37.9	30.5	24.8	24.6	25.6
AFDC male adult work program status: [1]								
Registered	68.4	NA	44.0	64.3	54.4	52.3	86.6	29.4
Exempt	29.0	NA	52.8	32.0	43.2	45.0	11.8	65.5
AFDC adults exempt from work programs—reasons for exemption:								
Aged, poor health	6.4	NA	3.4	9.2	5.1	23.5	1.7	28.1
Child under age	77.2	NA	85.5	65.4	80.4	56.1	66.5	44.4
Student and/or employed	1.5	NA	0.9	3.9	1.9	1.3	1.3	2.9
Other	14.8	NA	10.2	21.5	12.6	19.1	30.4	24.6
Percent with income	18.7	2.9	15.6	29.0	18.4	23.8	28.6	31.7
Average amount of income [2]	$253	$224	$231	$221	$270	$267	$321	$379
Percent with earned income	7.5	.5	5.9	12.0	7.2	5.6	18.2	11.5
Average monthly earned income [2]	$276	$352	$258	$273	$305	$282	$283	$298
Percent of earned income disregarded	45.0	6.8	48.1	46.8	46.3	38.8	40.4	41.5
Percent with unearned income	12.5	2.5	10.5	19.3	12.2	19.5	12.7	20.6
Average amount of unearned income [2]	$216	$191	$198	$162	$227	$245	$314	$371
Percent with countable assets	18.4	7.8	14.0	30.7	17.5	17.8	37.5	29.4

TABLE 25.—1986 AFDC CHARACTERISTICS—Continued

			One adult				Two adult	
	Total	No adult	Not married	Divorced or legally separated	Not legally separated or divorced	Other reasons	Unemployed parent	Other
Income of persons not in assistance unit:								
Percent with income	40.0	87.3	24.1	20.4	19.2	42.5	17.1	23.8
Average monthly amount [2]	$431	$433	$435	$425	$415	$431	$336	$372
Percent with earned income	4.9	7.1	4.7	5.1	3.6	1.8	1.7	1.6
Percent with public assistance income	34.1	85.9	16.2	11.6	12.5	37.2	12.7	18.4
Percent with unearned income	8.5	15.4	6.2	5.5	5.7	10.6	2.9	4.8

[1] "Unknown" category proportionally allocated.
[2] Average for those with income.
NA=Not applicable.

Source: Family Support Administration.

Tables 26 through 29 present selected 1986 characteristics of the AFDC population by State. Table 26 presents selected demographic characteristics, including the number of persons in the AFDC unit and household, the percent of units with household members not in the unit, the percent of units with no adult recipients and with one adult recipient, and the percentage distribution of the units by age of youngest child and race of parent. Table 27 presents selected income characteristics, including the percent of units with earned income, unearned income, and various income disregards. This table also supplies the average monthly amount of these sources of income for those receiving them. Finally, table 27 provides information on the percent of units participating in the food stamp program. Table 28 provides a detailed percentage distribution of AFDC units by shelter arrangement. Table 29 provides a detailed percentage distribution of AFDC units by the reason for deprivation of the youngest child.

TABLE 26.—SELECTED DEMOGRAPHIC CHARACTERISTICS OF AFDC UNITS, BY STATE, OCTOBER 1985–SEPTEMBER 1986

State	Average number in unit	Average number in household of unit	Percent of units			Percentage distribution by age of youngest child [1]			Percentage distribution by race of natural/adoptive parent [1] [2]		
			With household members not in unit	With no adult recipient	With 1 adult recipient	0–2 yrs.	3–5 yrs.	6 or more yrs.	White	Black	Hispanic
Alabama	2.9	4.7	60.8	18.4	80.1	39.1	20.8	40.0	17.7	82.2	0
Alaska	2.7	3.6	33.2	10.7	80.9	37.9	28.7	33.4	47.7	7.0	0.9
Arizona	2.9	4.3	55.9	16.8	81.1	43.5	22.1	34.4	29.4	11.3	35.4
Arkansas	3.0	4.6	57.0	14.8	84.1	37.2	22.3	40.4	33.2	66.3	.2
California	2.9	4.1	50.1	17.7	69.4	40.6	22.8	36.7	34.0	23.4	32.0
Colorado	3.0	3.1	4.6	8.5	87.3	43.6	21.2	35.2	41.4	14.8	40.9
Connecticut	3.0	3.6	30.6	8.8	87.7	38.4	23.0	38.7	32.6	34.3	32.3
Delaware	2.8	3.8	39.6	16.9	80.5	40.9	23.6	35.5	34.1	62.7	3.2
District of Columbia	2.8	3.8	45.7	16.2	81.6	37.2	23.6	39.2	.5	99.0	.5
Florida	2.9	4.3	57.3	21.8	77.8	43.0	22.9	34.1	25.8	61.4	12.1
Georgia	2.9	4.0	47.9	20.2	78.6	37.2	20.1	42.7	20.1	79.6	.1
Hawaii	3.2	3.5	16.9	6.8	73.9	41.9	21.8	36.3	23.2	.8	1.5
Idaho	2.8	3.2	21.1	8.9	85.5	37.8	26.9	35.3	86.1	.3	7.4
Illinois	3.1	3.8	34.5	11.8	80.1	39.0	22.6	38.5	29.7	61.1	8.5
Indiana	2.9	4.0	44.2	8.1	89.6	38.0	22.9	39.2	58.7	38.2	2.5
Iowa	2.9	3.2	18.0	8.2	75.3	35.5	23.7	40.8	86.9	11.0	.8
Kansas	3.1	3.8	34.4	12.4	73.2	43.8	23.3	32.9	62.9	29.5	4.3
Kentucky	2.7	3.9	51.6	14.1	84.3	29.4	23.9	46.7	77.5	22.2	0
Louisiana	3.0	4.5	57.2	15.2	84.2	42.0	21.9	36.1	14.7	83.9	.8
Maine	3.0	3.6	37.8	8.2	76.2	32.2	21.5	46.3	97.4	0	0

TABLE 26.—SELECTED DEMOGRAPHIC CHARACTERISTICS OF AFDC UNITS, BY STATE, OCTOBER 1985–SEPTEMBER 1986—Continued

State	Average number in unit	Average number in household of unit	Percent of units			Percentage distribution by age of youngest child [1]			Percentage distribution by race of natural/adoptive parent [1] [2]		
			With household members not in unit	With no adult recipient	With 1 adult recipient	0–2 yrs.	3–5 yrs.	6 or more yrs.	White	Black	Hispanic
Maryland	2.7	3.8	45.6	10.6	85.4	38.6	22.8	38.5	28.7	70.1	.4
Massachusetts	2.8	3.2	19.6	9.6	84.4	34.6	25.5	39.9	59.6	18.2	19.7
Michigan	3.1	3.4	13.1	3.1	81.9	37.3	21.2	41.5	48.9	48.1	2.4
Minnesota	3.0	3.5	25.9	6.1	78.6	39.1	25.1	35.9	75.7	11.5	1.2
Mississippi	3.1	5.1	61.3	15.8	82.8	42.1	21.1	36.8	11.7	87.6	.1
Missouri	3.0	4.0	43.0	11.9	81.0	39.0	23.8	37.1	53.7	45.8	.3
Montana	3.1	3.3	10.8	5.2	81.2	42.7	26.0	31.3	73.4	.7	2.8
Nebraska	3.0	3.8	35.2	15.5	74.3	45.1	21.9	33.0	64.7	27.2	2.4
Nevada	2.8	2.9	9.2	14.1	85.3	47.1	22.3	30.6	47.4	40.6	6.8
New Hampshire	2.7	2.8	13.5	12.0	86.2	38.7	23.0	38.3	97.0	.8	1.4
New Jersey	3.0	3.3	17.1	10.5	85.8	34.5	23.1	42.4	25.2	49.1	25.3
New Mexico	2.9	3.2	14.0	9.7	83.6	37.9	20.5	41.6	20.3	5.2	55.9
New York	3.1	3.6	25.8	7.0	84.2	37.1	23.6	39.3	24.7	36.3	38.5
North Carolina	2.7	4.1	52.1	14.1	84.0	31.2	23.9	44.9	23.7	72.6	.2
North Dakota	2.8	3.2	18.8	4.8	91.6	34.4	29.5	36.1	65.1	0	.6
Ohio	3.1	3.7	30.0	7.5	75.8	39.2	21.6	39.3	60.1	37.9	1.5
Oklahoma	3.0	3.8	36.2	10.2	86.8	36.8	21.8	41.4	50.6	33.1	2.0
Oregon	2.7	3.4	37.1	13.2	81.8	44.4	20.7	34.9	82.0	9.3	4.4
Pennsylvania	3.0	3.5	22.4	7.0	81.5	33.6	23.1	43.3	51.3	41.6	6.3
Rhode Island	2.8	3.0	9.8	7.8	85.1	38.2	23.2	38.7	69.6	15.5	11.9

South Carolina	2.9	4.7	59.2	18.7	79.5	35.2	23.9	40.8	15.8	84.0	.1
South Dakota	2.7	4.0	40.8	17.0	80.9	37.9	25.7	36.4	53.5	0	.3
Tennessee	2.8	4.1	56.6	17.3	81.3	37.4	21.6	41.0	41.7	58.1	0
Texas	3.1	4.3	45.6	15.2	82.1	41.8	22.2	36.0	16.1	40.7	41.6
Utah	3.0	3.4	24.5	9.1	86.7	45.7	27.3	27.0	77.6	4.4	9.8
Vermont	2.8	3.2	20.1	6.4	79.9	37.3	27.4	35.3	98.8	0	0
Virginia	2.6	4.2	61.2	18.9	79.2	36.3	21.2	42.5	29.3	69.0	.4
Washington	2.8	3.5	34.2	12.2	75.9	41.5	24.2	34.3	74.7	9.4	5.3
West Virginia	3.3	3.7	23.8	5.2	57.0	33.4	22.2	44.4	93.3	6.6	0
Wisconsin	3.0	3.5	26.3	9.4	73.5	42.3	21.6	36.1	61.2	29.3	3.4
Wyoming	2.8	3.3	27.0	11.8	86.3	38.3	25.8	35.9	70.8	5.1	13.8
U.S. Total	3.0	3.8	36.7	11.9	79.3	38.4	22.7	38.9	40.3	41.3	14.6

[1] Unknown category was distributed proportionately within States reporting proportions of unknown.

[2] Distribution does not add to 100 percent because it excludes "other" races.

Source: "Characteristics and Financial Circumstances of AFDC Recipients, 1986." U.S. Department of Health and Human Services.

TABLE 27.—SELECTED INCOME CHARACTERISTICS OF AFDC UNITS, BY STATE, OCTOBER 1985–SEPTEMBER 1986

State	Units with earned income		Units with unearned income		Units with income disregarded for child care		Units that have $30 plus one-third disregard		Percent of units participating in the food stamp program [2]
	Percent of total units	Average monthly amount (dollars) [1]	Percent of total units [1]	Average monthly amount (dollars) [1]	Percent of units with earned income	Average monthly amount (dollars) [1]	Percent of units with earned income	Average monthly amount (dollars) [1]	
Alabama	3.8	105	5.3	89	15.6	82	28.6	45	83.1
Alaska	10.0	479	28.4	501	9.4	76	59.6	122	65.5
Arizona	5.3	172	10.4	188	9.5	63	61.4	62	80.4
Arkansas	7.9	123	17.7	107	12.1	66	42.2	56	84.0
California	8.0	308	10.6	229	22.9	139	44.8	91	71.6
Colorado	10.1	263	26.3	245	19.3	95	54.6	82	80.6
Connecticut	6.6	297	15.9	188	NA	NA	57.2	92	80.4
Delaware	9.7	238	27.3	215	30.0	100	73.3	94	77.9
District of Columbia	4.0	323	4.5	158	25.9	102	51.8	63	NA
Florida	6.2	224	9.3	87	23.7	105	55.1	68	77.0
Georgia	4.8	180	17.8	105	14.1	46	28.3	69	78.6
Hawaii	10.5	213	6.0	207	14.8	115	44.3	59	61.6
Idaho	16.9	182	25.5	175	28.1	100	35.8	54	88.2
Illinois	4.8	235	8.4	147	27.1	105	49.9	65	88.5
Indiana	8.2	165	16.2	82	20.8	71	50.6	56	81.6
Iowa	17.7	228	17.5	188	22.9	101	48.6	81	87.7
Kansas	11.1	221	12.9	76	20.6	78	61.8	71	78.7
Kentucky	4.2	127	6.4	99	19.1	69	43.8	46	86.5
Louisiana	2.9	168	8.2	98	11.1	115	41.7	62	NA

Maine	19.5	281	24.0	125	31.7	103	44.4	96	86.2
Maryland	6.2	267	10.8	81	33.5	100	61.2	71	81.2
Massachusetts	8.0	275	16.4	206	33.9	89	55.8	77	79.8
Michigan	11.3	279	15.3	140	15.5	91	53.5	89	93.3
Minnesota	16.2	251	17.5	119	27.6	105	51.4	82	78.0
Mississippi	9.0	211	18.1	137	10.9	69	42.7	76	87.6
Missouri	8.9	196	11.3	94	23.1	98	57.6	66	82.0
Montana	17.4	223	16.9	214	18.0	112	48.1	70	90.7
Nebraska	10.1	235	10.7	148	8.1	80	51.3	86	85.2
Nevada	3.0	190	9.8	82	9.2	50	81.8	69	72.2
New Hampshire	13.3	196	25.8	97	7.5	50	45.3	79	80.5
New Jersey	4.4	236	3.1	212	17.8	92	57.0	78	85.8
New Mexico	4.5	193	17.6	206	17.4	68	67.9	74	88.1
New York	4.8	305	17.4	314	19.4	135	43.5	63	92.8
North Carolina	2.3	208	7.5	203	20.7	91	65.5	81	72.0
North Dakota	17.7	199	36.5	144	27.3	165	41.6	61	74.2
Ohio	5.9	223	9.4	171	8.3	98	54.2	84	89.3
Oklahoma	8.4	196	7.2	164	NA	NA	62.2	70	78.7
Oregon	14.2	220	16.8	119	34.7	111	62.4	60	90.2
Pennsylvania	8.0	208	4.1	149	25.7	96	57.5	71	88.4
Rhode Island	10.7	260	30.3	270	37.9	77	48.3	62	90.7
South Carolina	5.7	234	13.2	98	12.0	70	57.3	79	79.4
South Dakota	13.1	251	24.6	64	31.5	62	69.3	66	73.2
Tennessee	3.4	147	5.7	99	19.5	68	59.8	57	85.0
Texas	4.6	140	7.4	66	10.2	126	55.1	53	87.9
Utah	19.3	322	16.3	158	8.4	121	47.0	102	81.1

TABLE 27.—SELECTED INCOME CHARACTERISTICS OF AFDC UNITS, BY STATE, OCTOBER 1985–SEPTEMBER 1986—Continued

State	Units with earned income		Units with unearned income		Units with income disregarded for child care		Units that have $30 plus one-third disregard		Percent of units participating in the food stamp program [2]
	Percent of total units	Average monthly amount (dollars) [1]	Percent of total units [1]	Average monthly amount (dollars) [1]	Percent of units with earned income	Average monthly amount (dollars) [1]	Percent of units with earned income	Average monthly amount (dollars) [1]	
Vermont	14.0	314	21.9	139	32.6	149	47.8	90	84.1
Virginia	8.4	178	6.2	125	.5	50	47.6	65	58.9
Washington	10.3	263	22.9	298	18.9	108	62.7	78	83.9
West Virginia	8.4	121	32.7	136	1.4	60	34.8	71	92.8
Wisconsin	16.1	271	29.8	308	32.3	92	59.8	73	83.0
Wyoming	12.3	222	8.3	157	NA	NA	57.9	58	85.4
U.S. total	7.5	248	12.5	194	20.4	106	51.2	76	83.4

NA—No case samples available.

[1] Average amount for those with the income source or income disregard.

[2] Unknown category was distributed proportionately within States reporting proportions of unknown.

Source: "Characteristics and Financial Circumstances of AFDC Recipients, 1986", U.S. Department of Health and Human Services.

TABLE 28.—PERCENTAGE DISTRIBUTION OF AFDC UNITS, BY TYPE OF SHELTER ARRANGEMENT—OCTOBER 1985–SEPTEMBER 1986

State	Owns or is buying	Public housing	HUD rent subsidy	Other rent subsidy	Private housing (no subsidy)	Shares group quarters	Rents free	Unknown
Alabama	3.8	14.1	9.4	0.7	37.2	0.6	18.0	16.2
Alaska	9.0	15.2	7.2	5.6	43.7	1.3	11.7	6.2
Arizona	2.7	9.4	11.7	.4	55.9	.7	19.2	0
Arkansas	7.7	11.4	19.9	.7	31.3	6.5	22.5	0
California	1.9	3.2	5.2	.8	88.5	.2	0	.1
Colorado	5.3	8.1	10.0	3.3	65.7	5.1	1.1	1.4
Connecticut	1.0	17.5	16.8	.8	60.3	2.1	1.0	.4
Delaware	5.2	13.0	16.2	1.3	60.7	2.3	1.0	.3
District of Columbia	.9	13.9	14.5	3.3	65.1	1.3	.5	.5
Florida	2.5	10.9	11.2	1.2	68.9	.8	4.2	.2
Georgia	3.4	15.1	7.2	.8	25.8	1.8	6.9	39.0
Hawaii	1.6	10.1	12.7	1.9	53.9	13.6	6.0	.2
Idaho	6.6	8.9	16.1	7.2	49.8	5.8	5.4	.3
Illinois	3.5	13.1	5.6	.8	65.5	2.6	4.3	4.6
Indiana	5.0	7.3	15.9	1.0	68.4	.4	1.5	.5
Iowa	9.1	1.3	13.5	1.5	65.5	4.4	2.2	2.5
Kansas	4.3	8.2	7.7	.8	74.2	.3	4.3	.1
Kentucky	7.5	10.8	6.0	.3	44.3	.5	2.6	27.9
Louisiana	5.8	13.2	13.3	1.0	41.8	3.1	19.7	2.0
Maine	18.5	.1	1.4	13.8	51.0	0	6.2	9.0
Maryland	2.3	11.0	12.0	1.5	70.9	.6	1.1	.6
Massachusetts	3.2	14.5	15.3	6.2	55.1	3.1	2.0	.6
Michigan	14.3	4.5	4.5	1.5	69.9	.1	5.0	.3
Minnesota	13.0	8.1	15.7	4.1	55.0	.3	3.1	.6
Mississippi	6.8	4.4	10.8	.5	18.2	.7	24.7	34.0
Missouri	7.0	6.2	12.4	.9	58.7	.5	6.8	7.4
Montana	7.7	18.1	14.2	4.5	46.8	5.9	1.7	1.0
Nebraska	5.5	11.9	16.2	2.0	56.6	5.8	2.0	0
Nevada	0	24.2	16.1	1.6	49.0	0	7.6	1.4
New Hampshire	3.7	14.0	7.7	4.3	63.5	1.8	4.3	.7
New Jersey	1.9	7.8	3.8	1.5	81.5	2.2	.7	.6
New Mexico	16.2	11.6	18.7	3.1	32.9	9.1	7.1	1.3
New York	1.6	13.8	7.4	1.9	71.9	1.0	1.9	.5
North Carolina	5.5	15.4	13.1	.6	45.8	5.2	9.3	5.1
North Dakota	9.1	15.3	31.8	6.6	31.3	2.7	2.1	1.2
Ohio	5.0	11.1	11.6	1.5	66.4	.3	3.2	.8
Oklahoma	7.5	9.3	17.2	4.6	30.8	7.8	20.4	2.3
Oregon	3.6	4.3	15.7	1.7	68.1	3.4	2.2	1.0
Pennsylvania	4.7	12.8	4.6	1.0	65.7	2.5	.6	8.0
Rhode Island	3.9	12.2	17.2	.9	59.6	2.0	3.7	.6
South Carolina	5.2	6.3	12.6	.6	25.8	1.7	28.4	19.3
South Dakota	6.8	10.9	11.5	6.5	45.9	4.9	12.6	.9

TABLE 28.—PERCENTAGE DISTRIBUTION OF AFDC UNITS, BY TYPE OF SHELTER ARRANGEMENT—OCTOBER 1985–SEPTEMBER 1986—Continued

State	Owns or is buying	Public housing	HUD rent subsidy	Other rent subsidy	Private housing (no subsidy)	Shares group quarters	Rents free	Unknown
Tennessee	6.0	20.9	10.5	1.6	44.3	.6	13.3	2.7
Texas	7.5	9.9	18.1	1.6	29.2	9.4	24.2	.1
Utah	4.0	1.4	10.0	5.1	72.3	.2	7.0	0
Vermont	11.0	10.4	5.2	.3	63.7	4.9	4.0	.6
Virginia	2.7	16.7	10.1	1.6	48.5	3.4	5.0	12.0
Washington	5.2	7.4	10.7	1.5	72.9	.4	1.6	.3
West Virginia	15.7	4.9	9.7	.5	58.8	2.3	6.6	1.5
Wisconsin	7.9	6.4	5.8	1.7	72.6	2.3	2.8	.5
Wyoming	21.7	3.8	4.0	4.4	61.1	1.1	4.0	0
U.S. total	4.9	9.6	9.1	1.6	63.8	1.9	5.3	3.9

Source: "Characteristics and Financial Circumstances of AFDC Recipients, 1986". U.S. Department of Health and Human Services.

TABLE 29.—PERCENTAGE DISTRIBUTION OF AFDC UNITS BY REASON FOR DEPRIVATION OF THE YOUNGEST CHILD, OCTOBER 1985–SEPTEMBER 1986

State	Parent deceased	Parent incapacitated	Parent unemployed	Parent absent			Other	Unknown
				Divorced or legally separated	Not legally separated	Not married		
Alabama	1.1	3.3	0	11.4	14.9	67.9	0.9	0.5
Alaska	1.7	3.4	0	31.4	15.5	39.8	4.8	3.5
Arizona	1.2	2.9	0	16.5	20.9	55.0	2.1	1.4
Arkansas	1.8	3.7	0	15.4	14.1	63.1	1.8	0
California	2.4	3.2	11.9	16.1	15.7	45.7	1.8	3.4
Colorado	2.0	2.6	.2	24.5	17.3	47.0	1.0	5.6
Connecticut	2.1	2.1	2.0	13.0	15.3	63.1	1.4	1.0
Delaware	.6	2.3	1.3	12.3	10.4	69.2	2.6	1.3
District of Columbia	1.0	.9	15.2	3.9	9.4	66.4	.8	2.3
Florida	1.6	1.1	0	12.1	16.5	64.6	2.0	2.1
Georgia	2.3	2.3	0	11.6	16.1	66.1	1.3	.4
Hawaii	2.3	8.4	8.4	12.3	15.9	47.9	2.1	2.7
Idaho	0	2.4	0	36.5	16.3	41.0	2.2	1.7
Illinois	.9	1.2	6.5	10.3	15.3	64.3	.6	.8
Indiana	1.1	2.5	0	26.4	9.3	59.4	.9	.4
Iowa	1.1	4.4	13.2	30.2	11.2	38.1	1.0	.8
Kansas	1.0	4.2	9.2	24.1	13.4	44.9	1.1	2.1
Kentucky	1.4	10.5	0	21.5	19.7	46.5	.5	0
Louisiana	2.2	1.6	0	9.0	13.5	69.7	2.1	1.8
Maine	2.3	6.7	6.0	34.8	15.5	33.6	1.1	0

TABLE 29.—PERCENTAGE DISTRIBUTION OF AFDC UNITS BY REASON FOR DEPRIVATION OF THE YOUNGEST CHILD, OCTOBER 1985–SEPTEMBER 1986—Continued

State	Parent deceased	Parent incapacitated	Parent unemployed	Parent absent			Other	Unknown
				Divorced or legally separated	Not legally separated	Not married		
Maryland	1.3	1.7	1.9	9.3	14.5	67.7	.9	2.7
Massachusetts	1.6	3.1	3.5	16.4	17.9	53.3	1.8	2.4
Michigan	1.7	1.7	9.5	21.3	10.7	48.1	1.3	5.6
Minnesota	1.8	1.8	13.1	26.9	10.0	44.3	.4	1.8
Mississippi	1.6	2.9	0	7.7	16.3	70.5	.7	.2
Missouri	1.2	2.9	5.7	17.7	17.9	53.6	.9	.1
Montana	.3	2.1	6.6	32.0	11.1	39.5	2.5	5.9
Nebraska	1.1	2.0	8.2	21.6	12.3	49.7	1.2	3.9
Nevada	.5	1.4	0	16.6	16.3	62.1	.5	2.4
New Hampshire	1.7	3.8	0	31.1	18.2	42.3	2.0	.8
New Jersey	1.8	1.2	3.0	11.1	20.0	61.4	.7	.8
New Mexico	1.9	8.1	.2	18.8	20.1	45.8	3.0	2.1
New York	1.7	2.0	3.2	8.6	17.7	48.5	12.3	6.1
North Carolina	2.5	1.9	0	11.9	18.5	62.0	1.6	1.6
North Dakota	1.2	1.5	0	34.5	10.3	48.5	.9	3.1
Ohio	1.3	2.4	15.0	22.4	10.1	43.8	1.1	4.0
Oklahoma	1.8	3.6	.1	26.6	18.4	47.3	1.7	.6
Oregon	.9	2.6	2.8	24.4	21.5	43.5	3.0	1.4
Pennsylvania	1.5	3.8	5.2	14.9	19.6	52.3	1.4	1.3
Rhode Island	1.5	3.9	1.1	24.5	15.9	41.9	7.0	4.3
South Carolina	1.6	3.0	.6	7.1	24.8	61.8	1.0	.1
South Dakota	2.6	2.4	0	28.5	11.9	53.0	1.5	0
Tennessee	1.3	3.9	0	15.4	16.1	58.9	1.2	3.2
Texas	1.8	4.4	.2	13.1	23.6	54.7	1.9	.3
Utah	1.4	4.2	.7	28.9	21.4	37.8	.9	4.7
Vermont	.6	8.2	7.9	27.1	13.4	38.1	1.2	3.4
Virginia	1.4	3.7	0	11.7	16.2	55.4	1.3	.3
Washington	1.9	3.7	10.2	25.3	15.2	39.7	1.8	2.1
West Virginia	.7	6.5	29.5	16.7	18.5	24.5	.2	3.4
Wisconsin	1.7	2.6	14.7	22.2	6.8	46.4	1.0	4.8
Wyoming	.3	1.9	.3	39.5	14.1	39.4	1.9	2.7
U.S. total	1.7	2.8	6.2	15.9	15.8	52.6	2.5	2.6

Source: "Characteristics and Financial Circumstances of AFDC Recipients, 1986". U.S. Department of Health and Human Services.

LENGTH OF TIME ON WELFARE AND TURNOVER WITHIN THE AFDC CASELOAD

LENGTH OF TIME ON WELFARE

Average length of time on welfare.—A 1983 study of AFDC families[2] found that although most "spells" of AFDC are relatively short, most persons enrolled in the program at any point in time are in the midst of spells that last at least 8 years. As the first two columns of table 30 illustrate, the study reported that 50 percent of AFDC spells lasted less than 2 years and 62 percent lasted less than 4 years. At the same time, the study reported that 50 percent of the persons enrolled at a point in time were in the midst of very long episodes (8 or more years) of AFDC receipt, and such long-term recipients used most of the resources of the program.

The 1983 study has since been updated by one of its authors, because it understated the extent of long-term welfare dependence by neglecting to take into account the fact that multiple spells of welfare receipt are common (about one-third of all welfare spells are followed by subsequent spells). Accounting for multiple spells alters the distribution of total expected time on welfare, as the last two columns of table 30 illustrate. The fact remains, however, that while a significant percent of all persons on welfare will be enrolled for less than 2 years (30 percent) or less than 4 years (50 percent), a majority of persons enrolled in AFDC at a point in time are in the midst of what will be long periods of welfare receipt (65 percent).

TABLE 30.—DISTRIBUTION OF LENGTH OF TIME ON AFDC

[In percent]

Expected time on AFDC	Single spell analysis		Multiple spell analysis	
	Persons beginning a spell	Persons on AFDC at a point in time	Persons beginning first AFDC spell	Persons on AFDC at a point in time
1 to 2 years	48	14	30	7
3 to 4 years	14	10	20	11
5 to 7 years	20	25	19	17
8 or more years	17	50	30	65
All	100	100	100	100

This seemingly paradoxical finding that there are large differences between point-in-time and ever-began estimates of welfare dependency highlights a crucial element of welfare dynamics that is characteristic of the dynamics of spells of poverty and unemployment as well. The differences in the estimates occur because the probability of being on welfare (or being poor or unemployed) at a given time is necessarily higher for longer-term recipients than for those who have shorter welfare spells. Thus, the point-in-time welfare sample is a biased sample of *all* welfare recipients.

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[2] Bane, Mary Jo, and Ellwood, David T., The Dynamics of Dependence; The Routes to Self-Sufficiency. Prepared for the U.S. Department of Health and Human Services under contract No. HHS-100-82-0038, June 1983. (Prepared by Urban Systems Research and Engineering, Inc., Cambridge, Mass.)

An example of spells of hospitalization will help to establish this point. Consider a 13-bed hospital in which 12 beds are occupied for an entire year by 12 chronically ill patients, while the other bed is used by 52 patients, each of whom stays exactly 1 week. On any given day, a hospital census would find that about 85 percent of patients (12/13) were in the midst of long spells of hospitalization. Nevertheless, viewed over the course of a year, short-term use clearly dominates: out of the 64 patients using hospital services, about 80 percent (52/64) spent only 1 week in the hospital. Exactly the same dynamic accounts for the results with regard to welfare experience. One of the most important lessons from the longitudinal evidence is that while the welfare population at any point in time is composed predominantly of long-term users, the typical recipient is a short-term user.

Subgroup analysis of length of time on welfare.—Tables 31 and 32 present data on the length of time on welfare for various subgroups of the population. Table 31 is based on ever-began estimates of welfare receipt which take into account multiple spells. This table shows that the most powerful predictor of long-term welfare receipt is marital status. Single women average 9 years of AFDC receipt, and 39 percent are predicted to receive AFDC for 10 or more years. Race and work experience also seem to distinguish themselves among different subgroups of AFDC recipients. Blacks and those who did not work in the 2 years prior to their first receiving welfare are estimated to average over 8 years of AFDC receipt, and nearly one-third of each group are expected to receive AFDC for 10 or more years. Education may well be another important grouping: high school graduates seem to fare better than dropouts. However, these education-related estimates are less reliable because the sample size of those with less than 9 years of education is very small.

TABLE 31.—PERCENTAGE OF AFDC RECIPIENTS WITH VARIOUS CHARACTERISTICS AND AVERAGE TOTAL DURATIONS OF AFDC RECEIPT

Recipient characteristics at time of first spell beginning	Percent of all first-time recipients (new beginnings)	Percent of recipients at any point in time [1]	Average number of years of AFDC receipt	Percent who will have AFDC spells of 10 or more years
Age:				
Under 22	30.0	35.9	8.23	32.8
22 tc 30	40.7	41.9	7.08	25.8
31 to 40	11.8	8.8	5.15	15.0
Over 40	17.6	13.4	5.23	15.8
Race/ethnicity:				
White	55.2	47.7	5.95	19.6
Black	40.1	47.4	8.14	32.0
Other	4.8	4.8	6.94	25.5

TABLE 31.—PERCENTAGE OF AFDC RECIPIENTS WITH VARIOUS CHARACTERISTICS AND AVERAGE TOTAL DURATIONS OF AFDC RECEIPT—Continued

Recipient characteristics at time of first spell beginning	Percent of all first-time recipients (new beginnings)	Percent of recipients at any point in time [1]	Average number of years of AFDC receipt	Percent who will have AFDC spells of 10 or more years
Years of education:				
Under 9	9.7	9.6	6.81	24.5
9 to 11	37.6	41.9	7.65	29.2
Over 11	52.7	48.5	6.33	21.8
Marital status:				
Single	29.5	40.0	9.33	39.3
Divorced	28.1	20.2	4.94	13.7
Separated	32.3	31.9	6.80	24.4
Widowed	8.4	5.3	4.37	10.2
Number of children:				
0 to 1	43.4	48.7	7.71	29.7
2 to 3	42.8	37.3	6.04	20.1
Over 3	13.8	13.7	6.83	24.5
Age of youngest child:				
Under 3	51.3	60.4	8.09	31.9
3 to 5	22.5	22.3	6.79	24.2
6 to 10	19.7	12.9	4.51	11.3
Over 10	6.5	4.4	4.71	12.4
Work experience:				
Worked in the last 2 years	65.8	59.6	6.53	23.0
Did not work in the last 2 years	34.2	39.8	8.00	31.2
Disability status:				
No disability	81.6	81.4	6.85	24.8
Disability limits work	18.4	18.6	6.97	25.0

[1] These figures assume that the AFDC caseload is a "steady state."

Source: David T. Ellwood. "Targeting Would-Be Long-Term Recipients of AFDC," Table IV–1. Simulation model estimates are based on the 15-year panel study of income dynamics. For each individual who began a first spell on or after the third sample year of the PSID, probabilities are predicted for exiting from first spell, for recidivism, and for exiting from later spells, based on logit models.

Table 32 presents another approach to evaluating length of time on welfare. It takes a sample of the entire 1970 population, and chronicles welfare receipt patterns for the next 10 years. Eighty-five percent of this 1970 sample lived in familes in which no AFDC income was received in the following 9 year period, 1970–1979. Slightly fewer children (81.2 percent) received no AFDC. This table also presents data on individuals for whom AFDC and Food Stamps together constituted 50 percent of their family's annual income. Only 3.8 percent of all non-white Americans and 0.2 percent of all white Americans in this group were on welfare 8 to 10 years out of the total 10-year period. Note that these data do not describe the welfare receipt patterns of the population in anything but this 10-year window. Years of welfare receipt prior to and after this period are not accounted for.

TABLE 32.—WELFARE DEPENDENCY, 1970–79, BY VARIOUS DEFINITIONS OF DEPENDENCY

Years on welfare	Percent receiving AFDC			Percent receiving AFDC, and AFDC plus food stamps was at least 50% of total family income		
	Entire population	Children, age 0 to 5 in 1970	Women, age 18 to 55 in 1970	Entire population	Children, age 0 to 5 in 1970	Women, age 18 to 55 in 1970
All races:						
0 years	85.0	81.2	85.9	92.7	89.1	93.0
1 to 2 years	7.4	7.3	6.7	3.8	4.2	3.3
3 to 7 years	5.3	6.1	5.1	2.7	4.9	3.0
8 to 10 years	2.2	4.4	2.3	0.7	1.7	0.8
Total	100.0	100.0	100.0	100.0	100.0	100.0
White:						
0 years	89.9	87.3	90.7	95.7	93.6	96.0
1 to 2 years	5.7	5.9	4.9	2.6	3.0	2.1
3 to 7 years	3.3	4.4	3.1	1.7	3.0	1.6
8 to 10 years	1.1	2.4	1.2	0.2	0.4	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0
Nonwhite:						
0 years	58.1	49.4	58.5	76.1	65.3	76.0
1 to 2 years	16.9	14.6	16.3	10.5	11.0	10.0
3 to 7 years	16.6	21.6	16.8	9.6	15.4	10.4
8 to 10 years	8.6	14.5	8.4	3.8	8.3	3.6
Total	100.0	100.0	100.0	100.0	100.0	100.0

Table reads: 85.0 percent of the population lived in families in which no AFDC income was received during the 1970–79 period.

Source: Special tabulations of the Panel Study of Income Dynamics by Greg J. Duncan, 1986.

INTERGENERATIONAL "DEPENDENCY"

Intergenerational welfare dependency has been examined by researchers. Using data from the Panel Study of Income Dynamics, Hill and Ponza found in 1984 that most daughters in welfare-dependent families did not become welfare-dependent as young adults. As table 33 illustrates, only 19 percent of black daughters and 26 percent of white daughters in highly dependent welfare families became highly dependent themselves. It is also interesting to note that fully 42 percent of the black daughters and 27 percent of the white daughters who grew up in families which were heavily dependent on welfare received *no* welfare as young adults.

TABLE 33.—INTERGENERATIONAL TRANSMISSION OF WELFARE DEPENDENCY

Parental welfare status	Status of daughters as young adults			Total (percent)	Number of observations
	Received no welfare (percent)	Low welfare dependence	High welfare dependence		
Received no welfare:					
Black	53	33	14	100	108
White	79	19	2	100	354
Low welfare dependence:					
Black	31	49	20	100	130
White	63	31	5	100	75
High welfare dependence:					
Black	42	39	19	100	92
White	27	47	26	100	25

Note.—"High Welfare Dependence" is defined as receiving at least 25 percent of average family income as cash welfare payments. Parental measures are typically averaged over 7 years during the time the child is 10 to 16 years old. Measures on the children as young adults are typically measured over 7 years during the time the child is 24 to 30 years old.

Source: Hill, Martha S., and Ponza, Michael. "Does Welfare Dependency Beget Dependency?" Institute for Social Research, Fall 1984. Mimeo.

Source of data: Panel Study of Income Dynamics.

TURNOVER WITHIN THE AFDC CASELOAD

To further understand the dynamics of welfare receipt, data are available which describe which events in an individual's life provide the explanation for beginnings and endings of spells of AFDC receipt.

Beginnings of AFDC spells.—As table 34 illustrates, three-fourths of all spells in the PSID data set began with a relationship change that created a female-headed family with children. Almost half the AFDC spells started after a wife became a female family head (by loss of the male head and his earnings due to absence, divorce, separation, death). Another 30 percent began when a never-married, divorced, or separated woman acquired a child.

In contrast to changes in family composition, changes in earnings were a relatively minor cause of resorting to welfare. Only 15 percent of AFDC spells could be traced to a drop in family earnings.

Endings of AFDC spells.—The most common route out of AFDC was by way of a change in family structure. Some 46 percent of endings occurred this way—35 percent when a female head became a wife and 11 percent when the household no longer contained a child under 18.

Increased earnings were much more significant in ending AFDC than decreased earnings were in starting it. Some 26 percent of endings occurred this way—21 percent when the female head herself earned more money and 5 percent when another member of the family increased earnings.

Poverty status.—About 40 percent of those who ended AFDC spells were poor after their exit. About 52 percent of those whose AFDC eligibility ended because they no longer had an eligible child were poor in the following year. For those who earned their way off AFDC, about 32 percent were poor in the year after their welfare spell; their poverty reflected the sub-poverty gross income eligibility limits of AFDC in many States.

TABLE 34.—EVENTS ASSOCIATED WITH THE BEGINNINGS AND ENDINGS OF AFDC SPELLS

Beginnings	Percent	Endings	Percent
Divorce/separation	45	Marriage	35
Childless, unmarried woman becomes a female head with children.	30	Children leave parental home	11
Earnings of female head fell	12	Earnings of female head increased.	21
Earnings of others in family fell	3	Earnings of others in family increased.	5
Other income fell	1	Transfer income increased	14
Other (including unidentified)	9	Other (including unidentified)	14
All	100	All	100

Sources: "Beginnings": Bane and Ellwood (1983), p. 18, using PSID data. "Endings": Ellwood (1985), p. 46, using PSID data.

WELFARE RECEIPT OF TEENAGE MOTHERS

One of the subgroups at greatest risk for long-term welfare receipt is comprised of young never-married women who enter the AFDC program when their child is less than 3 years old. For example, it is estimated that over 40 percent of never-married women who enter the AFDC system at age 25 or less with a child less than 3 years old will spend 10 years or more on AFDC.[3] This subsection provides data on the number of teenage mothers in the United States and the proportion receiving AFDC, and presents data on some of the dynamics of their welfare receipt.

NUMBER OF TEENAGE MOTHERS

There are several different estimates of the number of teenage mothers in the United States. Probably the best estimates are based on data from the National Center for Health Statistics (NCHS). These are shown in table 35 below for 1983.

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[3] Ellwood, David T. "Targeting 'Would-Be' Long-Term Recipients of AFDC," prepared for the U.S. Dept. of Health and Human Services under contract No. 100-84-0059, June 1986. (Prepared by Mathematica Policy Research, Inc.)

TABLE 35.—NUMBER OF TEENAGE MOTHERS IN THE UNITED STATES BY CURRENT AGE AND AGE AT BIRTH OF FIRST CHILD, 1983

Current age	Total	Unmarried at time of first birth	Age at first birth	Total	Unmarried at time of first birth
Under 15	9,356	8,480	Under 15	58,022	51,674
15	32,423	27,164	15	123,269	97,417
16	81,745	62,271	16	209,684	143,377
17	162,432	111,149	17	244,180	144,205
18	275,386	167,672	18	213,931	108,236
19	411,735	219,272	19	123,971	51,099
Total	973,057	596,008		973,057	596,008

Source: Based on data from NCHS annual natality reports, 1978–83.

Preliminary NCHS data indicate that the number of teenage mothers had fallen to 907,000 by 1985, of which 581,000 were unmarried and 327,000 were married. Of the unmarried teenage mothers, 298,000 were white and 266,000 were black. Of the married teenage mothers, 300,000 were white, and 18,000 were black.

PROPORTION RECEIVING AFDC

Data from AFDC quality control records indicate that in 1983 the average monthly number of teenage mothers receiving AFDC was 236,000. Of these teenage mothers on AFDC, 199,000 were unmarried. Data from AFDC records suggest that by 1986, the number of teenage mothers had fallen to roughly 213,000, of which 172,000 were unmarried. Of these teenage mothers on AFDC in 1986, 52.3 percent were 19, 31.1 percent were 18, 10.5 percent were 17, 4.4 percent were 16, and the remainder were 15 and younger.

DYNAMICS OF AFDC RECEIPT

Table 36 describes the probability that an adolescent mother will begin to receive AFDC within the first 24 months after the birth of her first child.[4] Of these adolescents who had their first child between 1978 and 1984, about 27 percent reported receiving welfare at some point within the 12 months following the birth of that child. This proportion increased slightly to 28 percent in the subsequent 12 month period (13 to 24 months after birth).

Marital status at the birth of the first child. Adolescent mothers who were unmarried at the time of the birth of their first child were much more likely to receive welfare than were those teenage mothers who were married when they gave birth. Approximately 48 percent of the unmarried mothers received welfare for at least one month in the first year after the birth of their first child, compared with roughly 7 percent of those who were married when they gave birth.

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[4] In this table, adolescent mothers are defined as those who were between the ages of 15 and 19 when they had their first child. The mothers examined here had their first children between 1978 and 1984.

Both groups of young mothers were slightly more likely to receive welfare 13 to 24 months after giving birth than in the first 12 months after birth. As might be expected, mothers who were unmarried when they gave birth continued to be much more likely to receive welfare—namely, 50 percent of the unmarried mothers reported at least one month of welfare receipt 13 to 24 months after giving birth compared with about 8 percent of the married adolescents.

Although the differences in the recipiency rates of the two marital status groups are likely to be due to a number of factors, it is useful to recognize that marriage directly affects the eligibility of the young mother in at least two ways. First, married couples are not categorically eligible for AFDC in many States.[5] Second, even in States where couples are eligible, they are likely to have higher incomes than are unmarried adolescent mothers and thus are less likely to need or to qualify for benefits.

Age at the birth of the child. Mothers who were 15 to 17 years old when they gave birth were slightly more likely to report being on welfare in the first 12 months after birth (29 percent) than were 18- to 19-year-old mothers (26 percent). This difference becomes larger during the subsequent 12 months (13 to 24 months after giving birth), when the proportion of younger adolescent mothers who report receiving welfare in at least one month increased to 32 percent, while that of older adolescent mothers stayed fairly steady at 25 percent.

TABLE 36.—PROPORTION OF ADOLESCENT MOTHERS RECEIVING AFDC (FOR AT LEAST ONE MONTH) WITHIN THE FIRST 24 MONTHS AFTER THE BIRTH OF THEIR FIRST CHILD [1]

Characteristics of mother at time of birth of first child	Proportion receiving AFDC for at least one month in various periods after the birth of first child	
	0–12 months [2]	13–24 months
All	27	28
Marital status:		
Married	7	8
Unmarried	48	50
Age:		
15 to 17	29	32
18 to 19	26	25

[1] Adolescent mothers are defined as all women who were between the ages of 15 and 19 when they had their first child. Age and marital status are determined at the time of the birth of the child.

[2] Roughly 7 percent of the adolescent mothers reported receiving welfare during their pregnancy.

Source: Preliminary Congressional Budget Office calculations from the National Longitudinal Survey of Youth (1979–85).

Note: These estimates are based on first births to a group of adolescent women between 1978 and 1984. As the findings are based on small samples, they should be interpreted as general estimates of patterns of welfare recipiency rather than as precise estimates of actual population characteristics.

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[5] Through the AFDC-Unemployed Parent (AFDC-UP) program, States have the option to provide benefits to married couples where the principal earner is unemployed. In 1983, for example, 29 States did not provide AFDC-UP benefits—meaning that a married couple would not be eligible for assistance unless one was incapacitated.

The differences in the welfare recipiency patterns of adolescent mothers of different ages could be due to a number of factors. In particular, they are likely to be partially due to marital status differences between the two groups—the younger mothers in this sample were much less likely to be married than were older mothers. Other factors that might play a role include differences in living arrangements and in the likelihood of having a subsequent birth.

THE 1987 AMENDMENTS

In December of 1987, Congress enacted H.R. 3545, the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203). This new law includes four AFDC amendments, which are summarized below:

1. Fraud control under AFDC program.—Effective April 1, 1988, authorizes 75 percent Federal funding for the costs of a State's fraud control program.

2. Assistance to Homeless Families—Prohibits the Secretary of Health and Human Services, prior to October 1, 1988, from taking any action that would have the effect of implementing, in whole or in part, the proposed regulations published in the *Federal Register* on December 14, 1987. These regulations would have restricted the use of AFDC emergency assistance funds for homeless families and would have limited States' authority to make payments for special needs of AFDC recipients. The moratorium on promulgation of regulations is intended to give Congress an opportunity to determine whether and how the current AFDC statute should be amended to respond to the problems of homeless families.

3. Washington State Demonstration Program.—Allows the State of Washington to conduct a demonstration of its proposed Family Independence Program.

4. New York State Demonstration Program.—Allows the State of New York to test a child support supplement demonstration program as an alternative to the present AFDC program.

THE 1984 AMENDMENTS

In June of 1984, Congress enacted H.R. 4170, the Deficit Reduction Act of 1984 (Public Law 98-369). This new law, which took effect on October 1, 1984, includes 22 AFDC amendments and an income and asset verification amendment which affected several programs, and are summarized below:

1. Gross income limitation.—Under prior law, eligibility for AFDC was limited to families with gross incomes at or below 150 percent of the State standard of need. The act increases the gross income limitation to 185 percent of the State standard of need.

2. Work expense deduction.—Under prior law, States were required to disregard the first $75 of monthly earnings for full-time work expenses; a lower deduction applied to part-time workers. The act requires States to disregard the first $75 monthly for full and part-time workers.

3. Continuation of $30 disregard.—Under prior law, the $30 plus one-third of remaining earnings disregard was limited to 4 months. The act retains the 4-month limit on the one-third disregard but extends the $30 disregard for an additional 8 months for a total of 12 months.

4. Work transition status.—Under prior law, a family who lost AFDC eligibility due to the 4-month limit on the earnings disregard, simultaneously lost categorical eligibility for Medicaid. The act provides that families who lose AFDC because of the termination of the earnings disregard will be eligible for 9 months of Medicaid coverage. At State option, an additional 6 months of Medicaid coverage can be provided. In addition, families who lost AFDC eligibility prior to enactment of the work transition will also be eligible for Medicaid under certain specified circumstances.

5. Clarification of earned income provisions.—The act clarifies that the term "earned income" as used in the AFDC program means the gross amount of earnings, prior to the taking of payroll or other deductions.

6. Burial plots, funeral agreements and certain property.—Under prior law, burial plots and funeral agreements were counted toward the $1,000 asset limit. The act exempts from the AFDC resources limitation, burial plots and funeral agreements. An AFDC policy on real property that is similar to SSI policy is also established.

7. Federal matching for Community Work Experience Program (CWEP) expenses.—Under prior law, States were required to reimburse a CWEP participant for necessary transportation and other expenses. Federal matching for this reimbursement was by regulation, limited to $25 per month. The act requires States to reimburse a CWEP participant for costs incurred if the State is unable to provide directly any transportation or day care services. Reimbursement of day care expenses is limited to those determined by the State to be reasonable, necessary and cost effective up to $160 per month per child.

8. Retrospective budgeting and monthly reporting.—Under prior law, monthly reporting and retrospective budgeting were required for all AFDC cases; however, the Secretary of Health and Human Services could waive the monthly reporting requirement if it was not cost effective to require the report. The act mandates retrospective budgeting for cases filing a monthly report. Monthly reporting is required when cost effective; cases with earned income and recent work history must report monthly.

9. Earned income tax credit (EITC).—Under prior law, States were required to assume that an individual was receiving the earned income tax credit on an advance basis regardless of when or if it was received. The act requires States to count the EITC only when actually received.

10. Demonstrations of one-stop service delivery.—The act authorizes from 3 to 5 Federally-assisted demonstration projects designed to test the effectiveness and efficiency of integrating the delivery of human services.

11. Work requirements for pregnant women.—The act adds to those who are exempt from work registration, any woman who is in the third trimester of pregnancy.

12. Recalculation of lump sum income.—Under prior law, States could only recalculate ineligibility due to receipt of lump sum income if a life threatening circumstance occurred. The act allows States to recalculate the ineligibility period under other specified circumstances. Ineligibility may be recalculated if: (1) an event occurs which would have changed the amount of AFDC paid; (2) the income becomes unavailable for reasons beyond the family's control; and/or (3) the family incurs, becomes responsible for and pays medical bills which offset the lump sum income.

13. Overpayment recoupment.—Under prior law, States were required to attempt to recover all benefit overpayments. The act permits States to waive overpayment recovery when it is not cost effective. States will be permitted to automatically waive overpayments of less than $35. Larger overpayments must be collected unless the State determines, after attempting to collect the overpayment, that the cost to collect would exceed the amount owed.

14. Protective payments.—Under prior law, States were required to make protective payments to a third party when a parent on AFDC failed to meet certain statutory procedural requirements. The act permits States to make the payment to the parent if, after all reasonable efforts have been made, a suitable protective payee cannot be found.

15. Eligibility requirements for aliens.—Under prior law the income of an individual who sponsors a non-refugee alien was deemed to be available to the alien for 3 years after entry into the United States. The act establishes a similar policy for aliens who are sponsored by organizations or agencies.

16. Fugitive felons.—The act permits States to disclose the current address of an AFDC recipient if a law enforcement agency provides the correct social security number and demonstrates that the recipient is a fugitive felon.

17. Payment schedule for back claims.—The act establishes a payment schedule for court-ordered reimbursements and certain other back claims owed by the Federal Government to the States that have been allowed or are pending.

18. Work supplementation program.—The act modifies the existing work supplementation program to provide additional flexibility to States in operating grant diversion programs in which all or part of the AFDC grant can be used to subsidize a job.

19. Disregard of in-kind income.—The act extends, until October 1, 1987, the disregard of certain in-kind assistance provided on the basis of need.

20. Standard filing unit/child support payments.—There was no requirement in prior law that parents and all siblings be included in the AFDC unit. The act requires States to include in the filing unit the parents and all minor siblings living with a dependent child who applies for or receives AFDC. In addition, a monthly disregard of $50 of child support received by a family is established.

21. CWEP work for Federal agencies.—The act permits Federal agencies or offices to serve as community work experience program (CWEP) sites under the same requirements as apply to other sites.

22. Earned income of full-time students.—For purposes of applying the gross income limitation, the act allows States to disregard the income of an AFDC child who is a full-time student.

23. Income and eligibility verification procedures.—Under present law, IRS wage information furnished by employers to IRS is available to State welfare agencies for use in their AFDC and food stamp programs, and to the Social Security Administration for administering the SSI program. However, IRS unearned income information (filed by a financial institution or corporation with respect to payments to individuals in the form of interest, dividends, etc.) is not available to Federal and State agencies for use in the administration of these programs. Quarterly wage information from the unemployment compensation program is available to State welfare agencies in most States.

Public Law 98-369 provides for the IRS to disclose return information with respect to unearned income to Federal, State, or local agencies administering AFDC, SSI, Medicaid, food stamps, and the cash assistance programs administered in Puerto Rico, Guam, and the Virgin Islands.

Disclosure can only be made to agencies that meet the requirements to safeguard this confidential information against disclosure, and verification of the unearned income information is required prior to taking action to reduce or terminate benefits.

The provision also replaces existing statutory provisions relating to use (for purposes of AFDC) of return and other wage information and use of social security numbers, by adding a new section to the Social Security Act requiring States to have in effect an income and eligibility verification system for use in administering the AFDC, Medicaid, unemployment compensation, and food stamp programs (and the adult assistance programs in the territories). State agencies must request and make use of: (1) wage and other income information available under the Internal Revenue Code; and (2) quarterly wage information. Each State is required as of September 30, 1988, to maintain a quarterly wage reporting system, although not necessarily through its unemployment compensation system.

The income and eligibility system requires use of standardized data formats to facilitate exchange of information, for the purpose of identifying and reducing ineligibility and incorrect payments.

IMPACT OF 1981 PROGRAM CHANGES

The Omnibus Budget Reconciliation Act of 1981 (OBRA) imposed a gross income limit for AFDC eligibility (150 percent of a State's need standard), capped the deduction for child care costs ($160 monthly per child), set a standard deduction for other work expenses ($75 monthly), and ended the work incentive disregard for working recipients after their first 4 months on a job. These provisions affected AFDC parents with jobs by reducing or ending their benefits. They also had potential effects on welfare mothers without jobs by reducing the gains possible from work, and on nonwelfare mothers with low earnings. Under previous law, a person in the latter group could increase total income by decreasing or ending earnings, enrolling in AFDC, and then resuming work. OBRA also required States to count part of the income of a stepparent as available to an AFDC child.

Former HHS Assistant Secretary Rubin reported in testimony that 408,000 families lost eligibility and 299,000 lost benefits as a result of the OBRA changes. The changes saved the Federal and State governments about $1.1 billion in 1983. This implies an average loss in benefits per family of $1,555 per year.

HHS evaluation of the 1981 AFDC amendments

A study commissioned by the Department of Health and Human Services [6] and prepared by Research Triangle Institute compared a national sample of AFDC families before and after OBRA.

Major findings include:

—Earners in the 1981 sample (after OBRA) were more likely than 1980 earners (before OBRA) to be off the AFDC rolls a year later. The share of September 1981 earners no longer on welfare in October 1982 was 55 percent. Of September 1980 earners, 28 percent no longer were enrolled in the program a year later.

—The rates of return to AFDC after leaving the rolls were "similar" for the two groups.

—For both groups, approximately 18 percent of AFDC recipients who began the base year (1980 or 1981) with earnings no longer had a job at the end of the year and were receiving AFDC. This suggested that a "normal" rate of job loss occurred in both years and that OBRA had not induced a widespread change in behavior.

—Of the September 1981 earners who no longer received an AFDC payment a year later, approximately 87 percent were working. Their average monthly earnings were $704. (Because of a low response rate to the follow-up survey of former AFDC recipients, however, the report said these data "must be interpreted cautiously.")

—The unemployment rate seemed to have relatively little effect on AFDC participation and on earnings of AFDC recipients.

GAO evaluation of the 1981 amendments

At the request of the House Ways and Means Committee, the U.S. General Accounting Office conducted an in-depth evaluation of the effect of the 1981 amendments on individual AFDC families in five cities: Boston, Dallas, Memphis, Milwaukee, and Syracuse. GAO examined case records, analyzed 10 years of HHS program data, and interviewed former working AFDC recipients more than a year after their termination from AFDC due to the 1981 amendments.

Findings include:

—Once the declines in caseload and outlays stabilized, OBRA had decreased the national AFDC-basic monthly caseload by 493,000 cases and monthly outlays by $93 million. However, because the caseload rose faster than predicted after this point, long-term effects are less certain.

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[6] Final report, Evaluation of the 1981 AFDC Amendments, prepared by Research Triangle Institute under task order #1, contract No. 600-82-0095, and submitted to Office of Family Assistance, Social Security Administration, April 15, 1983.

—Working AFDC recipients who lost eligibility due to the OBRA cuts were more likely to be non-white, younger than those who remained on AFDC (28–33) and had been working for their current employer between 1.7 and 3.4 years.

—Recipients who lost AFDC eligibility suffered a substantial loss of income which they could not make up by increased earnings or other means. The average *monthly* income loss for working single parent families who lost AFDC eligibility was $186 in Memphis, $229 in Dallas, $180 in Milwaukee, $151 in Syracuse, and $115 in Boston.

—A large number of families interviewed had fallen below the poverty level after the OBRA changes were implemented. This ranged from a high of 85.5 percent of families below poverty in Memphis to a low of 28 percent of the Milwaukee families interviewed in poverty.

—Lack of health coverage was common among these former AFDC recipients. In Dallas, 59.2 percent of those families who lost AFDC did not have any health coverage. In Memphis, 45 percent, in Boston 27.5 percent, in Syracuse, 17.1 percent and in Milwaukee, 13.9 percent had no health coverage at all. Private health insurance coverage was more common in high AFDC benefit States.

—Families terminated from AFDC were more likely to face increased emergency situations. In several sites, significantly more families had to forgo medical treatment or were refused medical and/or dental treatment because they could not pay. It was also more common for these families to run out of food before the end of the month, have to seek food from a church or charity group, or need to borrow $50 or more from friends or relatives to meet expenses. In all but one site, those terminated from AFDC said they are eating worse now than before.

BUDGETARY ESTIMATES OF 1981–84 LEGISLATIVE CHANGES IN THE AFDC PROGRAM

The 97th Congress made several changes in AFDC, most of which were estimated to reduce outlays in the program. The 98th Congress also amended AFDC, reversing some of the 1981 cuts. Below is a list of major provisions and the Federal outlay changes attributed to them by the Congressional Budget Office (CBO).

TABLE 37.—CBO ESTIMATES OF 1981, 1982, AND 1984 AFDC LEGISLATIVE CHANGES

[Millions of dollars by fiscal year]

	1982	1983	1984	1985	1986	1987
1981 CHANGES (PUBLIC LAW 97-35)						
Limit and standardize earnings disregards	−345	−315	−325	−330	−330	NA
Change determination of resources	−16	−17	−17	−17	−17	NA
Permit offset for food stamps and housing subsidies	(1)	(1)	(1)	(1)	(1)	NA
Permit community work experience programs	NA	NA	NA	NA	NA	NA
Treat lump-sum payments as income	−5	−5	−5	−5	−5	NA
Count some income of stepparents living with dependent child	−154	−145	−136	−127	−118	NA
Exclude family of a striker from eligibility	−5	−5	−5	−5	−5	NA
Lower age limit of dependent child	−50	−52	−54	−56	−57	NA
Limit AFDC for pregnant women	−20	−21	−21	−23	−23	NA
Recover overpayments/pay under-payments	NA	NA	NA	NA	NA	NA
Reduce Federal matching for training	−16	−17	−18	−20	−20	NA
Require retrospective accounting and monthly reporting	(1)	−35	−65	−65	−65	NA
Eligibility of aliens for AFDC	−15	−15	−15	−15	−15	NA
Administrative savings	−11	−14	−18	−22	−26	NA
Total—AFDC [2]	−637	−641	−679	−685	−681	NA
1982 CHANGES (PUBLIC LAW 97-248)						
Round benefits down		−9	−10	−10	−10	−10
Prorate benefits to application date		−13	−14	−14	−14	−14
End military service absence as eligibility grounds		−15	−17	−17	−17	−18
Permit State job search			NA	NA	NA	NA
Permit proration of shelter and utilities		(1)	(1)	(1)	(1)	(1)
Change error rate sanctions		0	0	−62	−63	−63
Exclude certain State payments from countable income		0	0	0	0	0
Extend WIN demonstration		0	0	0	0	0
Exclude State payments to children		0	0	0	0	0
Technical amendments		+1	0	0	0	0
Exclude home energy assistance		+1	+2	+2	0	0
Total AFDC provisions [2]		−35	−39	−101	−104	−105
Food stamp impact of AFDC provisions [2]		+16	+18	+18	+18	+19

TABLE 37.—CBO ESTIMATES OF 1981, 1982, AND 1984 AFDC LEGISLATIVE CHANGES—Continued

[Millions of dollars by fiscal year]

	1982	1983	1984	1985	1986	1987
1984 CHANGES (PUBLIC LAW 98–369)						
185 percent gross income limit				5	10	10
Raise part-time work expense deduction				20	20	20
Continue $30 for 12 months				10	10	10
Work transition Medicaid						
Optional MRRB				(1)	(1)	(1)
Count EITC only when received				8	3	3
Exempt burial plots				3	3	3
Reimburse CWEP expenses				5	5	5
Integrated service delivery					2	2
Clarify earned income definition			−5	−24	−24	−24
Standard filing unit				−135	−140	−145
$50 child support disregard [3]				115	115	115
Income verification				(1)	−30	−20
Total AFDC provisions			−5	7	−26	−21
Medicaid impact of AFDC provisions				145	175	195
Food stamp impact of AFDC provisions				−19	−21	−21
Net impact			−5	133	128	153

[1] Savings or costs of less than $5 million annually.

[2] Does not include any resulting impact on the medicaid and food stamp program.

[3] Includes the change made to Public Law 98–378 relating to calculation of the incentive payment to States.

NA—Not available.

Section 8. Child Support Enforcement Program

BACKGROUND

The enactment of the Child Support Enforcement (CSE) program in 1975 represented a major new commitment on the part of the Congress to address the problem of nonsupport of children. Although prior to that time the Social Security Act had included provisions which were aimed at improving the collection of support on behalf of children with absent parents, these provisions had not proved to be effective. The 1975 amendments were aimed at strengthening in a very significant way the efforts of the Federal and State governments to improve the enforcement of child support obligations.

The 1975 legislation (Public Law 93-647) added a new part D to title IV of the Social Security Act. The statute authorizes Federal matching funds to be used for enforcing the support obligations owed by noncustodial parents to their children and the spouse (or former spouse) with whom the children are living, locating absent parents, establishing paternity, and obtaining child and spousal support. Basic responsibility for administering the program is left to the States, but the Federal Government also plays a major role in funding, monitoring and evaluating State programs, providing technical assistance, and in certain instances, in giving direct assistance to the States in locating absent parents and obtaining support payments from them. The program requires the provision of child support enforcement services for both welfare and nonwelfare families and States must frequently publicize, through public service announcements, the availability of child support enforcement services, together with information about the application fee and a telephone number or address to be used to obtain additional information.

WHO IS SERVED

Each State's plan must provide that the child support agency will undertake to secure support for an AFDC child whose rights to support have been assigned to the State. This includes nearly all AFDC children, since assignment of rights to support is a condition of eligibility for AFDC benefits. The State must also provide in its plan that it will undertake to establish the paternity of an AFDC child who is born out of wedlock. These requirements apply in all cases except where, in accordance with standards established by the Secretary, the State finds that to apply them would be against the best interests of the child. For families whose AFDC eligibility ends due to the receipt of (or an increase in) child support, States must continue to provide child support enforcement services, without imposing the application fee, discussed below, that is required for non-AFDC cases. This policy was established by Public Law 98-378.

With respect to non-AFDC families, the law provides that the State must make available, once an application is filed with the State agency, the child support collection and paternity determination services which are provided under the plan for AFDC families. The State must charge non-AFDC families an application fee of up to $25. The amount of the maximum allowable fee may be adjusted periodically by the Secretary of the Department of Health and Human Services to reflect changes in administrative costs. States may charge the fee against the custodial parent, pay the fee out of State funds, or recover it from the noncustodial parent.

States also have the option of charging a late payment fee equal to between 3 and 6 percent of the amount of overdue support. Late payment fees may be charged to the noncustodial parents of AFDC and non-AFDC families and are to be collected only after the full amount of the support has been paid to the child. In addition, a State may at its option recover costs in excess of the application fee. Such recovery may be from either the custodial parent or the noncustodial parent. If a State chooses to make recovery from the custodial parent, it must have in effect a procedure whereby all persons in the State who have authority to order support are informed that such costs are to be collected from the custodial parent.

Finally, child support enforcement services must include the enforcement of spousal support, but only if a support obligation has been established with respect to the spouse, the child and spouse are living in the same household, and child support is being collected along with spousal support.

THE FEDERAL ROLE

The Federal statute provides that the child support program must be administered by a separate organizational unit under the control of a person designated by and reporting directly to the Secretary of Health and Human Services. Under the present organizational structure of the Department, this office is known as the Federal Office of Child Support Enforcement (OCSE).

A primary responsibility of the director is to establish such standards for State programs for locating absent parents, establishing paternity, and obtaining child support and support for the spouse (or former spouse) with whom the absent parent's child is living as he determines to be necessary to assure that the programs will be effective. In addition to this broad statutory mandate, the director is required to establish minimum organizational and staffing requirements for State child support agencies, and to review and approve State plans.

The statute also requires the director of the OCSE to provide technical assistance to the States to help them establish effective systems for collecting child and spousal support and establishing paternity. To fulfill this requirement, the OCSE has established a National Child Support Enforcement Reference Center as a central location for the collection and dissemination of information about State and local programs. It has created a National Institute for

Child Support Enforcement to provide training and technical assistance to persons working in the field of child support enforcement. Special initiatives, such as a recent effort to assist major urban areas in improving program performance, have also been undertaken by the OCSE.

The Child Support Enforcement Amendments of 1984 (Public Law 98-378) extend the research and demonstration authority in section 1115 of the Social Security Act to the child support enforcement program. This will make it possible for States to test innovative approaches to support enforcement so long as the modification would not disadvantage children in need of support nor result in an increase in Federal AFDC costs. Public Law 98-378 also authorizes special project grants to promote improvement in interstate enforcement. The authorization is $7 million in fiscal year 1985, $12 million in fiscal year 1986, and $15 million in fiscal year 1987 and thereafter.

The director of the OCSE has full responsibility for program evaluation. Prior to fiscal year 1984 the statute required him to conduct an annual audit of each State's program to determine whether the actual operation of the program conformed to Federal requirements. The penalty for noncompliance was a reduction of 5 percent in the Federal matching that would otherwise be payable to the State under the Aid to Families With Dependent Children (AFDC) program. This penalty was never imposed; legislation was periodically enacted to suspend its implementation.

Public Law 98-378 modified these audit and penalty requirements. Audits are now required at least every 3 years to determine whether the standards and requirements prescribed by law and regulations have been met. Under the penalty provision, a State's AFDC matching funds must be reduced by an amount equal to at least 1 but no more than 2 percent for the first failure to comply substantially with the standards and requirements, at least 2 but no more than 3 percent for the second failure, and at least 3 but no more than 5 percent for the third and subsequent failures.

FEDERAL ENFORCEMENT TOOLS

The statute creates several Federal mechanisms to assist the States in performing their paternity and child support enforcement functions. These include use of the Internal Revenue Service, the Federal courts, and the Federal Parent Locator Service (FPLS).

The statute requires the Secretary of HHS, upon the request of a State, to certify to the Secretary of Treasury for collection by the IRS any amounts identified by the State as representing delinquent child support payments. The Secretary may certify only the amounts delinquent under a court or administrative order, and only upon a showing by the State that it has made diligent and reasonable efforts to collect amounts due using its own collection mechanisms. States must reimburse the Federal Government for any costs involved in making the collections. Collections may be made on behalf of both AFDC and non-AFDC families. Use by the States of this regular IRS collection mechanism (which may include seizure by the IRS of property, freezing of accounts, and other procedures) has been relatively infrequent. In fiscal year

1986, collections were made in only 886 cases nationwide, for a total collection of $489,018.

The availability of the IRS collection mechanism for child support was amplified in amendments enacted as part of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) to allow, in addition, the collection of past support from Federal tax refunds upon a simple showing by the State agency that an individual owes at least $150 in past-due support which has been assigned to the State as a condition of AFDC eligibility. Upon receiving this showing, the Secretary of Treasury is required to withhold from any tax refunds due that individual an amount equal to any past-due support. The withheld amount is sent to the State agency, together with notice of the taxpayer's current address.

Public Law 98-378 created a similar IRS offset program for non-AFDC families owed child support. States must submit to the IRS for withholding, the names of absent parents who have arrearages of at least $500 and who, on the basis of current payment patterns and the enforcement efforts that have been made, are unlikely to pay the arrearage before the IRS offset can occur. The law establishes specific notice requirements and mandates that the absent parent and any spouse be informed of the procedures which may be taken to protect the unobligated spouse's portion of the refund. The provision applies to refunds payable after December 31, 1985, and before January 1, 1991.

In fiscal year 1987, a total of 664,472 cases were offset, which resulted in child support collections of $345 million. About 84 percent of the offset cases and 79 percent of the child support collections were for AFDC recipients. The remainder was for non-AFDC cases.

States also may have access to the Federal courts to enforce court orders for support. The director of the Office of Child Support Enforcement must approve a State's application for permission to use the courts of the United States to enforce court orders for support upon a finding that: (1) another State has not undertaken to enforce the court order of the originating State against an absent parent within a reasonable time; and (2) that use of the Federal courts is the only reasonable method of enforcing such order. This mechanism, designed to assist the States in enforcing interstate cases, has gone unused, apparently because the States view it as costly and complex.

Finally, the statute also requires the establishment of a Federal Parent Locator Service to be used to find absent parents in order to enforce child support obligations. Upon request, the Secretary of HHS must provide to an authorized person the most recent address and place of employment of any absent parent if the information is contained in the records of the Department of Health and Human Services, or can be obtained from any other department or agency of the United States or of any State. The Secretary must also make available the services of the PLS to any State that wishes to locate an absent parent or child for the purpose of enforcing any Federal or State law with respect to the unlawful taking or restraint of a child, or making or enforcing a child custody determination.

THE STATE ROLE

Each State is required to designate a single and separate organizational unit of State government to administer the program. Earlier child support legislation, enacted in 1967, had required that the program be administered by the welfare agency. The 1975 act deleted this requirement in order to give each State the opportunity to select the most effective administrative mechanism. Most States have placed the child support agency within the social or human services umbrella agency which also administers the AFDC program. However, two States have placed the agency in the department of revenue. The law allows the programs to be administered either on the State or local level. Ten programs are locally administered. A few programs are State administered in some counties and locally administered in others.

States must have plans, approved by the director of the OCSE, which set forth their functions and responsibilities. Both AFDC and non-AFDC families must be served. States must also enter into cooperative arrangements with appropriate courts and law enforcement officials to assist the child support agency in administering the program. These agreements may include provision for reimbursing courts and law enforcement officials for their assistance. States must operate a parent locator service to locate absent parents, and they must maintain full records of collections and disbursements, and otherwise maintain an adequate reporting system.

In order to facilitate the collection of support in interstate cases, a State must cooperate with other States in establishing paternity, locating absent parents, and in securing compliance with an order issued by another State.

The law requires the States to use several enforcement tools. They must use the IRS tax refund offset procedure for AFDC and non-AFDC families, and they must also determine periodically whether any individuals receiving unemployment compensation owe child support obligations. The State employment security agency is required to withhold unemployment benefits, and to pay the child support agency any outstanding child support obligations established by an agreement with the individual or through legal processes.

Public Law 98-378 mandated that States use a number of other enforcement techniques, beginning on October 1, 1985. These include: (1) mandatory wage withholding if support payments are delinquent in an amount equal to one month's support; (2) imposing liens against real and personal property for amounts of overdue support; (3) withholding of State tax refunds payable to a parent who is delinquent in support payments; (4) making available information regarding the amount of overdue support owed to a consumer credit bureau upon a request; (5) requiring individuals who have demonstrated a pattern of delinquent payments to post a bond or give some other guarantee to secure payment of overdue support; (6) establishing expedited processes within the State judicial system or under administrative processes for obtaining and enforcing child support orders, and, at the option of the State, determining paternity; (7) notifying each AFDC recipient at least once each year of the amount of child support collected on behalf of that recipient; (8) permitting the establishment of paternity until a child's 18th birthday; and (9) at the option of the State, providing that child support payments must be made through the agency that administers the State's income withholding system if either the custodial or noncustodial parent requests that they be made in this manner.

State child support agencies are required to undertake child support collections on behalf of children receiving foster care maintenance payments under title IV-E of the Social Security Act, if an assignment of rights to support has been secured by the foster care agency. In addition, foster care agencies are required to take steps, where appropriate, to secure an assignment to the State of any rights to support on behalf of a child receiving foster care maintenance payments.

State agencies are also required, as a result of Public Law 98-378 and regulations issued by the Department of Health and Human Services, to petition to include medical support as part of any child support order whenever health care coverage is available to the noncustodial parent at a reasonable cost. And, if a family loses AFDC eligibility as the result of increased collection of support payments, the State must continue to provide Medicaid benefits for 4 calendar months beginning with the month of ineligibility.

Finally, the statute requires each State to comply with any other requirements and standards that the Secretary determines to be necessary to the establishment of an effective child support program.

FEDERAL GARNISHMENT AND MILITARY ALLOTMENT PROVISIONS

Title IV-D of the Social Security Act also includes a provision allowing garnishment of wages and other payments made by the Federal Government for enforcement of child support and alimony obligations. The statute provides that moneys (the entitlement to which is based upon remuneration for employment) payable by the United States to any individual are subject to legal process brought for the enforcement against such individual of his legal obligation to provide child support or make alimony payments. The law sets forth in detail the procedures which must be followed for service of legal process, and specifies that the term "based upon remuneration for employment" includes wages, periodic benefits for the payment of pensions, retirement or retired pay (including social security and other retirement benefits), and other kinds of Federal payments. The following Federal income sources may not be garnished: any payment as compensation for death under any Federal program; Federal "black lung" benefits; Veterans' Administration pensions or payments as compensation for a service-related disability or death; and amounts paid to defray employment-related expenses.

As amended by Public Law 97-248, the law presently requires allotments from the pay and allowances of any member of the uniformed service (on active duty) when he fails to make child (or child and spousal) support payments. The requirement arises when the service member fails to make support payments in an amount at least equal to the value of 2 months' worth of support. Provisions of the Consumer Credit Protection Act apply so that the percentage of the member's pay which is subject to allotment is limited. The amount of the allotment is the amount of the support payment, as established under a legally enforceable administrative or judicial order.

FINANCING

Through fiscal year 1987, the Federal Government paid 70 percent of State and local administrative costs for services to both AFDC and non-AFDC families on an open-end entitlement basis. The matching rate was reduced from 75 to 70 percent by a provision in Public Law 97-248. Under the terms of Public Law 98-378, the matching rate declines to 68 percent in fiscal years 1988 and 1989, and 66 percent in fiscal year 1990 and each year thereafter. Funding for services to non-AFDC families was originally enacted on a temporary basis, but was made permanent in Public Law 96-272.

In addition, 90 percent Federal matching is available on an open-end entitlement basis to States that elect to establish an automatic data processing and information retrieval system. The Secretary must approve the system as meeting specified criteria before matching may be paid to the State. The matching rate was increased from 75 to 90 percent in Public Law 96-265. Public Law 98-378 permits States to use this 90 percent Federal match to establish an automated data processing and information retrieval system and, at the option of the State, for the development and improvement of the income withholding and other procedures required by the new law. These matching funds may also be used to pay for the acquisition of computer hardware.

Effective March 1, 1986, the Balanced Budget and Emergency Deficit Control Act of 1985 (P.L. 99-177) reduced the fiscal year 1986 administrative match from 70 percent to 66.65 percent and the computer match from 90 percent to 85.69 percent. These reductions applied to fiscal year 1986 only, and returned to the statutorily set rates on October 1, 1986.

Collections made on behalf of AFDC families are used to offset the cost to the Federal and State governments of welfare payments made to the family, except that AFDC families retain the first $50 of child support collected in a month. (Table 1 shows the number of families affected by this provision.) The amounts retained by the government are distributed between the Federal and State governments according to the proportional matching share which each has under a State's AFDC program.

TABLE 1.—ESTIMATED TOTAL NUMBER AND PERCENT OF AFDC FAMILIES AFFECTED BY $50 PASSTHROUGH: 1985, 1986, AND 1987 [1]

State	Number of AFDC families 1987	Estimated number of families affected 1987	Percent of families affected		
			1985	1986	1987
Alabama	47,231	13,122	11.7	18.0	18.5
Alaska	7,446	1,581	11.9	11.5	14.2
Arizona	29,298	1,832	4.8	4.5	4.2
Arkansas	22,786	6,955	15.9	17.3	20.4
California	584,842	88,581	13.8	11.0	10.1
Colorado	31,437	6,582	14.1	14.1	14.0
Connecticut	38,661	18,925	25.6	27.6	32.6
Delaware	7,827	2,858	21.7	25.2	24.3
District of Columbia	19,825	2,138	5.8	1.8	7.2
Florida	103,698	22,994	11.4	15.1	14.8
Georgia	86,335	15,122	5.3	10.4	11.7
Guam	1,382	200	10.5	12.0	9.7
Hawaii	14,108	3,188	20.5	10.7	15.1
Idaho	6,480	2,899	46.7	32.7	29.8
Illinois	236,557	30,739	5.5	10.8	8.7
Indiana	52,920	17,847	25.9	14.3	22.5
Iowa	39,704	11,564	22.7	21.6	19.4
Kansas	24,793	6,506	15.2	17.3	17.5
Kentucky	59,536	8,512	7.6	8.1	9.5
Louisiana	86,155	9,977	6.9	7.3	7.7
Maine	19,260	8,460	25.6	26.9	29.3
Maryland	66,393	13,471	15.0	19.5	13.5
Massachusetts	87,716	25,750	20.2	20.0	19.6
Michigan	214,410	102,037	17.2	25.3	31.7
Minnesota	54,554	16,472	22.5	27.0	20.1
Mississippi	58,017	4,913	4.8	4.9	5.7
Missouri	67,286	10,185	8.2	9.8	10.1
Montana	9,484	1,516	13.9	15.4	10.7
Nebraska	15,951	3,673	11.3	15.3	15.4
Nevada	5,727	3,040	33.6	36.4	35.4
New Hampshire	4,329	1,215	12.6	17.7	18.7
New Jersey	115,100	27,471	15.4	15.4	15.9
New Mexico	19,708	2,175	7.6	11.6	7.4
New York	355,497	57,396	9.2	9.5	10.8
North Carolina	67,529	18,278	15.0	43.3	18.0
North Dakota	5,060	2,027	25.1	25.5	26.7
Ohio	227,066	40,228	11.6	14.4	11.8
Oklahoma	33,423	5,088	8.4	9.9	10.2

TABLE 1.—ESTIMATED TOTAL NUMBER AND PERCENT OF AFDC FAMILIES AFFECTED BY $50 PASSTHROUGH: 1985, 1986, AND 1987 [1]—Continued

State	Number of AFDC families 1987	Estimated number of families affected 1987	Percent of families affected		
			1985	1986	1987
Oregon	30,157	8,843	16.0	19.3	19.6
Pennsylvania	186,522	52,574	16.3	19.8	18.8
Puerto Rico	54,489	3,588	4.7	4.0	4.4
Rhode Island	15,751	4,184	13.9	14.0	17.7
South Carolina	45,409	10,931	8.9	8.8	16.1
South Dakota	6,600	2,745	17.6	33.8	27.7
Tennessee	65,721	9,547	9.8	10.0	9.7
Texas	157,329	10,227	3.1	4.5	4.3
Utah	14,646	5,586	26.9	25.8	25.4
Vermont	7,568	2,924	21.9	26.4	25.8
Virgin Islands	1,120	241	10.2	NA	14.4
Virginia	56,721	14,358	14.9	17.0	16.9
Washington	75,478	21,400	18.0	25.3	18.9
West Virginia	36,955	2,300	6.6	7.7	4.2
Wisconsin	96,146	33,849	37.8	23.3	23.5
Wyoming	4,760	742	8.0	11.1	10.4
Total	3,782,903	799,555	13.2	14.6	14.1

NA = Not available.

[1] These estimates are based on the number of "paying" child support cases and are a low estimate of the number of families affected.

Note: These estimates are based on the number of "paying" child support cases adjusted for comparability with AFDC families.

Source: Office of Child Support Enforcement.

Finally, the statute includes an incentive system designed to encourage State and local governments to participate in the program. As a result of Public Law 98-378, the prior incentive formula, which gave States 12 percent of their AFDC collections (paid for out of the Federal share of collections), has been replaced, beginning on October 1, 1985, with a new formula that is designed to encourage States to develop programs that emphasize collections on behalf of both AFDC and non-AFDC families, and to improve program cost effectiveness. The basic incentive payment will be equal to 6 percent of the State's AFDC collections and 6 percent of its non-AFDC collections. States may qualify for higher incentive payments, up to a maximum of 10 percent of collections, if their AFDC or non-AFDC collections exceed total administrative costs for the program.

The total dollar amount of incentives paid for non-AFDC families could not exceed the amount of the State's incentive payment for

AFDC collections for fiscal years 1986 and 1987. However, after 1987 the incentive paid for non-AFDC collections is capped at an amount equal to 105 percent of the incentive for AFDC collections in fiscal year 1988, 110 percent in fiscal year 1989, and 115 percent in fiscal year 1990 and thereafter.

DEMOGRAPHIC TRENDS

A sizable and growing proportion of American households are families that consist only of a mother and her children. Since 1970, the number of female-headed families has increased by about 127 percent; the number of two-parent families has declined 5 percent. As a result, by 1985 nearly one out of every five children in the United States lived in a family where the mother was never married or the father was absent because of death, divorce, or separation. An unprecedented number of children live in single-parent homes, many without adequate or any support from the other parent.

In 1985, 45 percent of families with children under 18 maintained solely by the mother had incomes below the poverty threshold. Further, 19 percent of these families with a female householder (with no husband present) were poor despite full-time work of the mother.

In 1985, almost 15 million children lived with only one parent, 78 percent more than in 1970. Even though the total number of children under 18 years old in the United States declined from 69 million in 1970 to 62.5 million in 1985, the number of children affected by divorce, separation, and unmarried status of mother continued to rise. About 23 percent of all children lived in a one-parent family in 1985, compared with 12 percent in 1970. The 1981 National Survey of Children indicates that roughly 10 percent of the children living with two parents were living with a stepparent.

Of the 15 million children living with one parent, 89 percent lived with their mothers and 11 percent with their fathers. Between 1970 and 1985 the number of children living with only their fathers grew by 108 percent (from 748,000 to 1,554,000). The proportion of all children in one-parent families who lived with their fathers rose from 1.1 percent to 2.5 percent.

The largest number of children in one-parent families had a parent who was divorced, followed by children whose parents were never married or separated. In 1985, of the children who lived only with one parent, 41 percent had a parent who was divorced, 26 percent had a parent who was separated, and 26 percent had a parent who had never been married. The number of children with a divorced parent has more than doubled since 1970, but the number with a never-married parent grew by a multiple of 6.

Child support awards

In 1985, of the 8.8 million women who had children present under the age of 21 from an absent father, 39 percent never were awarded child support rights (nor had an agreement to receive child support payments) and, thus, were dependent for income on sources other than the father. For poor mothers, the proportion without child support awards was even higher, 60 percent (see table 3).

TABLE 2.—CHILD SUPPORT AND ALIMONY PAYMENTS IN 1978, 1983, AND 1985

[Women as of spring 1979, 1984, and 1986. Child support payments for women with own children under 21 years of age present from an absent father: alimony payment for ever-divorced women]

Year, award and recipiency status of women	1978		1983		1985	
	Number (thousands)	Percent distribution	Number (thousands)	Percent distribution	Number (thousands)	Percent distribution
Child Support Payments						
Total	7,094	100.0	8,690	100.0	8,808	100.0
Awarded [1]	4,196	59.1	5,015	57.7	5,396	61.3
Supposed to receive payments	3,424	48.3	3,995	46.0	4,381	49.7
Not supposed to receive payments	772	10.9	1,020	11.7	1,015	11.5
Not awarded [1]	2,898	40.9	3,675	42.3	3,411	38.7
Supposed to receive payments	3,424	100.0	3,995	100.0	4,381	100.0
Actually received payments	2,455	71.6	3,037	76.0	3,243	74.0
Received full amount	1,675	48.9	2,018	50.5	2,112	48.2
Received partial amount	779	22.7	1,019	25.5	1,131	25.8
Did not receive payments	969	28.4	958	24.0	1,138	26.0
Alimony						
Total	14,334	100.0	17,392	100.0	19,156	100.0
Awarded [1]	2,052	14.3	2,416	13.9	2,803	14.6
Supposed to receive payments	760	5.3	791	4.5	840	4.4
Not supposed to receive payments	1,292	9.0	1,625	9.3	1,963	10.2
Not awarded [1]	12,282	85.7	14,976	86.1	16,354	85.4
Supposed to receive payments	760	100.0	791	100.0	840	100.0
Actually received payments	528	69.5	608	76.9	616	73.3
Received full amount	312	41.1	NA	NA	NA	NA
Received partial amount	216	28.4	NA	NA	NA	NA
Did not receive payments	232	30.5	183	23.1	225	26.8

[1] Award status as of spring 1979, 1984, and 1986.

Source: U.S. Bureau of the Census. Current Population Reports, Series P-23, No. 112 Child Support and Alimony 1978, No. 141 Child Support and Alimony 1983 (advance report) and No. 152. Child Support and Alimony 1985 (advance report). Washington U.S. Government Printing Office, 1987.

Approximately 5.4 million women with children under age 21 (61 percent) had been awarded child support or had an agreement to receive child support payments, but only 4.4 million (50 percent) of the women were actually "supposed to receive" child support in 1985. The rights of the remaining 11 percent were no longer in force because the father who owed payments had died, the children had grown past the age of eligibility for payments, or because of another such reason.

Many of the women who were awarded child support payments did not receive the full amount they were due. In 1985, less than half (48 percent) of the 4.4 million women owed child support payments received the full amount, about 26 percent of the women received less than they were owed, and 26 percent received no payment at all. The average amount of child support for women who *received* payments in 1985 was $2,215, about 15 percent of their average total income. In 1978, the average amount of child support was $1,800, about 20 percent of the woman's income.

In 1985, the average amount of child support for the 4.4 million women *due* payments, including those who received nothing, was $1,640. If the full amount of payment due had been made to these women, the average child support amount would have been $2,500. In 1985, $10.9 billion in child support payments was due, but actual payments totaled only $7.2 billion.

TABLE 3.—CHILD SUPPORT PAYMENTS AWARDED AND RECEIVED IN 1985—WOMEN WITH CHILDREN PRESENT, BY SELECTED CHARACTERISTICS

[Women with own children under 21 years of age present from an absent father as of spring 1986]

Characteristics of women	Total (thousands)	Percent awarded child support payments [1]	Supposed to receive child support in 1985			
			Total (thousands)	Actually received support in 1985		
				Percent	Mean child support	Mean income
	ALL WOMEN					
Total	8,808	61.3	4,381	74.0	$2,215	$14,776
Current Marital Status						
Married [2]	2,322	82.0	1,416	68.5	1,966	13,512
Divorced	3,045	81.8	2,179	75.1	2,538	16,778
Separated	1,363	43.1	453	84.3	2,082	12,642
Widowed [3]	69	(B)	30	(B)	(B)	(B)
Never married	2,009	18.4	303	76.2	1,147	9,675
Race and Spanish Origin						
White	6,341	70.6	3,651	74.6	2,294	15,052
Black	2,310	36.3	657	72.0	1,754	13,297
Spanish origin [4]	813	42.1	282	68.1	2,011	11,505
Years of School Completed						
Less than 12 years	2,230	45.2	750	67.1	1,835	9,144
High school: 4 years	4,176	63.3	2,152	74.3	2,040	13,577
College:						
1 to 3 years	1,653	70.7	1,003	74.6	2,447	17,014
4 years or more	748	76.6	476	82.1	2,978	22,639
	WOMEN WITH INCOMES BELOW POVERTY					
Total	2,797	40.4	905	65.7	1,383	5,130

TABLE 3.—CHILD SUPPORT PAYMENTS AWARDED AND RECEIVED IN 1985—WOMEN WITH CHILDREN PRESENT, BY SELECTED CHARACTERISTICS—Continued

[Women with own children under 21 years of age present from an absent father as of spring 1986]

Characteristics of women	Total (thousands)	Percent awarded child support payments [1]	Supposed to receive child support in 1985			
			Total (thousands)	Actually received support in 1985		
				Percent	Mean child support	Mean income
Current Marital Status						
Married [2]	180	67.2	81	61.7	(B)	(B)
Divorced	795	71.9	499	60.3	1,522	5,295
Separated	646	34.2	158	73.4	1,503	4,994
Widowed	18	(B)	4	(B)	(B)	(B)
Never Married [3]	1,159	17.9	163	75.5	900	5,450
Race						
White	1,569	50.2	631	65.1	1,463	5,005
Black	1,190	27.1	257	67.7	1,085	5,403
Spanish origin [4]	414	24.2	74	(B)	(B)	(B)

[1] Award status as of spring 1986.

[2] Remarried women whose previous marriage ended in divorce.

[3] Widowed women whose previous marriage ended in divorce.

[4] Persons of Spanish origin may be of any race.

Note.—B base less than 75,000.

Source: U.S. Bureau of the Census. Current Population Reports, Series P-23, No. 152. Child Support and Alimony: 1985 (Advance Report). U.S. Government Printing Office, Washington, 1987.

Of the 8.8 million women with children by an absent father, about 2.8 million (32 percent) had incomes below the poverty level. Of these women, only 32 percent (905,000) had agreements to receive child support and were due payments in 1985. Another 11.5 percent had agreements but were not due payments in 1985 (see table 3).

Of the poor mothers who were supposed to receive child support payments in 1985, 65.7 percent (595,000) actually received payments, while 34.3 percent did not.

For women who actually received child support payments in 1985, the amount of payment tended to be higher than average for divorced women, white women, women over age 30, and women who had gone to college for at least a year. Those with lower than average payment amounts included never-married women, black women, women of Spanish origin, and women who had not completed 12 years of school (see table 3).

Only 18 percent of women who had never married were awarded child support payments; compared with nearly 82 percent of divorced women, 82 percent of remarried women and 43 percent of women who were separated. Among women with awards, the percentages of those who actually received payments were: 62 percent of never-married mothers, 51 percent of remarried mothers, 65 percent of separated mothers, and 66 percent of divorced mothers.

Of the 3 million women who actually received child support payments in 1985, 50 percent were divorced, 30 percent were remarried, 12 percent were separated, and 7 percent were single (never married). The women who had never married received, on the average, the lowest amount of child support payments. Among women who were poor despite having been awarded child support, these percentages were lower. Payments actually were received by 59 percent of such never-married mothers, 41 percent of remarried mothers, 53 percent of separated mothers, and 53 percent of divorced mothers.

Black mothers and mothers of Spanish origin living apart from the father of their children were much less likely than their white counterparts to be awarded child support. Almost 71 percent of white mothers were awarded child support payments, compared with 36 percent of black mothers, and 42 percent of mothers of Spanish origin. Further, both black and Spanish-origin mothers received smaller payments, on the average, than did white mothers.

Mothers who were not high school graduates were less likely than the average to be awarded child support, and their support payments were on the average much smaller than those of mothers who had completed more than 12 years of school.

In addition, the age of the woman was related to the awarding of child support payments. Women between the ages of 30 and 39 were the most likely to be awarded child support. However, women 40 years of age and older were the most likely to actually receive payments and received, on average, higher support payments. Women under age 30 were the least likely to be awarded payments, and those who were awarded support received smaller payments, on average, than older women.

Another factor related to child support was the number of children the mother had with her in the absence of their father. Women with two children were the most likely to receive support.

PROGRAM TRENDS

The Child Support Enforcement program has grown significantly since its implementation in August 1975. From fiscal year 1978 through fiscal year 1987, more than $21.6 billion in child support payments have been collected: $8.8 billion on behalf of families receiving AFDC, and $12.8 billion on behalf of non-AFDC families.

In fiscal year 1987 collections on behalf of AFDC families exceeded $1.3 billion; collections on behalf of non-AFDC families totaled $2.5 billion. Total administrative expenditures were about $1,058 million, resulting in $3.68 collected per dollar of total administrative expenses. In fiscal year 1987, the number of parents located totaled 1,150,000, and the number of paternities established reached 255,000. The number of AFDC and non-AFDC cases in which a collection was made also continued to grow, as did the dollar amount of collections. Tables 4-22 present data showing the development of the child support program in recent years. In all of these tables, the 1987 data are preliminary.

TABLE 4.—PROGRAM OPERATIONS, SUMMARY OF NATIONAL STATISTICS, FISCAL YEARS 1978–1987

[Numbers in thousands, dollars in millions]

	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987
Total child support collections	$1,047	$1,333	$1,478	$1,630	$1,770	$2,024	$2,378	$2,696	$3,249	$3,897
Total AFDC collections	$472	$597	$603	$671	$786	$880	$1,000	$1,092	$1,225	$1,359
Total non-AFDC collections	$575	$736	$874	$958	$984	$1,144	$1,378	$1,604	$2,023	$2,538
Total administrative expenditures	$312	$383	$466	$526	$612	$691	$723	$814	$938	$1,058
Federal incentive payments to States and localities	$54	$66	$72	$90	$107	$121	$134	$131	$158	$185
Average number of AFDC cases in which a collection was made	458	463	503	548	597	595	647	684	582	604
Average number of non-AFDC cases in which a collection was made	249	224	243	325	448	507	547	654	786	931
Number of families removed from AFDC due to child support collections	19	27	40	46	32	26	41	34	[2]248	190
Number of parents located	454	574	643	696	779	831	875	878	1,046	1,150
Number of paternities established	111	138	144	164	173	208	219	232	245	255
Number of support obligations established	315	349	374	414	462	496	573	669	731	812
Percent of AFDC assistance payments recovered through child support collections	(1)	5.6	5.2	5.2	6.8	6.6	7.0	7.3	8.6	9.2
Total child support collections per dollar of total administrative expenses	$3.35	$3.48	$3.17	$3.09	$2.89	$2.93	$3.29	$3.31	$3.46	$3.68

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[1] Not available.

[2] Definition changed to all cases closed where a child support payment was received.

Source: Office of Child Support Enforcement.

TABLE 5.—STATE PROFILE OF COLLECTIONS AND EXPENDITURES, FISCAL YEAR 1987 [1]

[In millions of dollars]

State	Total collections	AFDC collections	Non-AFDC collections	Total expenditures
U.S. total	3,897.1	1,358.9	2,538.1	1,058.7
Alabama	40.0	15.1	24.9	14.9
Alaska	17.1	4.2	12.9	5.6
Arizona	20.1	4.8	15.3	9.1
Arkansas	16.3	8.8	7.5	5.5
California	394.9	198.2	196.7	156.5
Colorado	22.4	11.2	11.2	11.8
Connecticut	57.2	26.4	30.8	19.7
Delaware	13.9	4.2	9.7	4.5
District of Columbia	5.7	2.9	2.8	5.5
Florida	81.8	33.5	48.3	41.5
Georgia	48.1	25.2	22.8	15.2
Guam	.6	.3	.3	.4
Hawaii	16.0	5.7	10.3	5.2
Idaho	13.5	5.0	8.5	3.3
Illinois	89.6	38.7	50.9	35.8
Indiana	60.6	37.8	22.8	11.6
Iowa	49.3	28.2	21.1	7.9
Kansas	22.2	12.2	10.0	8.6
Kentucky	32.5	11.7	20.8	12.5
Louisiana	40.1	15.8	24.3	17.6
Maine	22.4	15.6	6.9	6.0
Maryland	92.7	31.1	61.6	32.4
Massachusetts	128.8	54.0	74.9	37.8
Michigan	531.1	127.5	403.6	55.9
Minnesota	79.5	35.8	43.7	22.7
Mississippi	15.4	7.6	7.8	4.6
Missouri	60.5	23.5	37.0	15.8
Montana	5.3	3.4	2.0	1.7
Nebraska	37.7	6.2	31.5	7.2
Nevada	9.8	2.7	7.2	4.3
New Hampshire	17.5	2.7	14.8	3.3
New Jersey	245.7	58.9	186.9	44.0
New Mexico	8.7	4.1	4.6	4.4
New York	269.2	102.1	167.1	137.5
North Carolina	69.9	33.3	36.7	18.2
North Dakota	5.5	3.5	2.0	2.1
Ohio	180.7	66.9	113.8	32.0
Oklahoma	16.4	7.1	9.2	7.4
Oregon	53.5	14.7	38.7	13.3
Pennsylvania	455.2	77.9	377.3	60.8
Puerto Rico	66.2	1.8	64.4	3.5
Rhode Island	11.9	6.2	5.8	3.6
South Carolina	33.6	13.2	20.4	11.2
South Dakota	6.2	3.0	3.2	2.1
Tennessee	38.4	12.1	26.3	12.5
Texas	61.2	19.7	41.5	23.5
Utah	24.8	11.7	13.0	10.4
Vermont	5.8	4.2	1.6	2.0
Virgin Islands	3.0	.2	2.8	.9
Virginia	58.9	15.5	43.3	26.4
Washington	72.3	38.4	33.9	28.3
West Virginia	9.7	5.7	4.1	4.9
Wisconsin	154.7	57.5	97.2	25.0
Wyoming	3.2	1.5	1.7	.7

[1] Totals may not add because of rounding. Preliminary data as of February 11, 1988.

Source: Office of Child Support Enforcement.

TABLE 6.—TOTAL CHILD SUPPORT COLLECTIONS, SELECTED FISCAL YEARS 1979–87

[In thousands of dollars]

State	1979	1981	1983	1984	1985	1986	1987 [1]
Alabama	6,854	5,021	8,643	11,978	25,532	32,499	39,976
Alaska	3,844	5,932	9,704	10,307	10,794	12,832	17,139
Arizona	6,411	8,755	10,563	14,247	12,874	13,730	20,114
Arkansas	3,921	4,856	7,401	7,809	9,988	14,865	16,267
California	199,945	201,426	254,586	285,804	305,096	336,569	394,882
Colorado	4,020	12,302	17,178	15,129	18,324	19,056	22,376
Connecticut	23,033	29,602	39,227	43,160	48,210	54,478	57,182
Delaware	5,814	6,945	8,097	9,758	10,698	12,232	13,871
District of Columbia	1,086	1,909	3,521	3,993	4,692	5,185	5,691
Florida	10,524	16,932	19,080	42,753	45,751	63,136	81,759
Georgia	5,554	8,304	13,439	18,586	26,281	35,276	48,082
Guam	160	149	391	485	433	487	627
Hawaii	5,150	7,547	10,087	10,272	11,642	11,791	15,985
Idaho	2,501	3,277	4,690	4,726	5,815	10,954	13,490
Illinois	10,740	13,943	32,025	42,876	54,530	72,647	89,622
Indiana	9,073	12,339	20,789	26,048	33,683	47,012	60,613
Iowa	13,017	21,522	29,185	33,140	34,350	40,558	49,325
Kansas	3,975	6,908	9,921	10,888	11,430	16,416	22,199
Kentucky	4,881	14,732	19,702	22,365	25,145	27,957	32,456
Louisiana	12,678	17,833	26,754	27,407	34,259	39,932	40,047
Maine	4,574	5,677	10,235	12,052	14,121	17,731	22,421
Maryland	20,856	35,193	77,129	76,637	83,807	95,737	92,706
Massachusetts	36,338	52,955	72,319	84,059	98,339	109,312	128,809
Michigan	248,414	305,396	273,799	305,421	341,178	424,647	531,137
Minnesota	21,370	29,988	44,893	52,152	58,850	68,889	79,467
Mississippi	1,662	2,510	4,887	5,300	6,895	11,798	15,431
Missouri	5,829	12,364	18,118	24,818	34,520	54,998	60,482
Montana	1,213	1,698	2,415	2,894	3,906	4,631	5,328
Nebraska	2,468	10,832	20,044	24,212	29,906	34,206	37,667
Nevada	3,487	4,011	5,556	6,441	7,280	8,977	9,844
New Hampshire	2,089	2,336	11,621	11,884	12,771	14,203	17,542
New Jersey	94,005	104,853	143,225	183,372	200,155	229,570	245,697
New Mexico	1,680	2,748	4,614	5,523	6,292	7,978	8,672
New York	136,361	141,670	174,454	182,541	199,550	221,953	269,218
North Carolina	9,168	17,196	30,830	37,292	45,042	55,381	69,895
North Dakota	1,723	1,936	2,723	3,372	3,645	4,665	5,483
Ohio	22,832	31,467	34,862	41,570	82,700	124,745	180,696
Oklahoma	1,826	3,224	5,233	7,545	9,233	12,977	16,365
Oregon	88,502	105,670	38,052	37,401	39,778	49,150	53,470
Pennsylvania	186,718	222,548	285,829	327,663	371,163	414,802	455,184
Puerto Rico	1,916	2,459	31,985	85,211	54,265	59,211	66,164
Rhode Island	3,575	3,772	7,196	7,910	8,634	10,466	11,915
South Carolina	3,545	5,323	7,461	11,078	11,063	21,756	33,581
South Dakota	1,407	1,768	2,847	2,732	3,154	4,473	6,184
Tennessee	8,976	10,217	19,077	22,295	23,562	31,390	38,406
Texas	8,207	11,633	17,941	25,004	30,311	43,209	61,184
Utah	6,624	9,710	13,594	14,666	16,759	22,316	24,766
Vermont	1,449	2,199	2,828	2,879	3,683	4,636	5,781
Virginia	9,197	9,904	13,617	13,954	16,278	2,038	3,020
Virgin Islands	260	429	684	1,479	2,339	24,610	58,859
Washington	27,018	31,756	41,643	46,035	56,830	61,151	72,320
West Virginia	1,592	2,349	3,434	3,977	4,691	5,701	9,724
Wisconsin	34,267	42,195	56,041	65,434	82,071	121,260	154,701
Wyoming	520	781	1,017	1,253	1,231	2,511	3,229
Nationwide total	1,332,847	1,629,000	2,024,184	2,377,788	2,693,528	3,248,690	3,897,051

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[1] Preliminary data as of February 11, 1988.

Source: Office of Child Support Enforcement.

TABLE 7.—TOTAL DISTRIBUTED AFDC COLLECTIONS, SELECTED FISCAL YEARS 1979–87

[In thousands of dollars]

State	1979	1981	1983	1984	1985	1986	1987 [1]
Alabama	6,830	5,021	7,789	8,778	14,863	14,454	15,050
Alaska	334	772	1,780	1,728	2,058	2,797	4,242
Arizona	642	1,221	1,459	2,165	1,636	2,725	4,805
Arkansas	2,428	2,684	4,593	5,183	6,318	8,084	8,771
California	117,532	100,437	136,963	151,998	154,024	172,414	198,152
Colorado	3,525	4,505	9,330	8,986	9,372	11,136	11,155
Connecticut	11,416	15,684	20,628	21,945	23,606	26,081	26,403
Delaware	1,386	2,001	2,276	3,501	3,847	3,987	4,150
District of Columbia	907	1,379	2,421	2,242	2,609	2,769	2,912
Florida	8,598	12,289	10,408	30,587	26,261	28,202	33,511
Georgia	4,772	7,441	11,355	14,816	19,268	21,456	25,244
Guam	159	117	259	296	281	273	299
Hawaii	2,544	3,127	4,482	4,489	5,162	5,138	5,698
Idaho	2,047	2,659	3,806	3,870	4,324	4,804	5,034
Illinois	9,916	12,347	18,971	24,415	27,936	32,392	38,706
Indiana	8,116	10,129	17,646	22,541	24,585	29,703	37,775
Iowa	10,654	15,218	19,978	22,518	23,858	26,016	28,184
Kansas	3,454	5,279	7,807	8,119	9,781	10,298	12,155
Kentucky	4,615	4,314	6,316	6,388	9,440	11,200	11,676
Louisiana	5,244	7,429	9,641	10,328	13,043	14,456	15,798
Maine	4,133	4,732	8,402	9,696	10,528	12,796	15,557
Maryland	10,929	15,912	27,773	24,202	28,197	31,529	31,083
Massachusetts	29,145	38,243	40,476	42,919	46,343	50,398	53,962
Michigan	76,375	87,304	97,694	106,771	111,925	125,426	127,508
Minnesota	14,510	20,290	25,708	28,600	30,805	33,921	35,822
Mississippi	1,556	2,284	4,544	4,901	4,807	5,928	7,599
Missouri	4,165	6,423	11,500	14,332	16,978	18,728	23,525
Montana	685	1,039	1,834	2,273	3,195	3,438	3,365
Nebraska	2,083	3,022	3,675	4,279	5,863	5,816	6,160
Nevada	517	879	1,824	1,759	1,731	2,860	2,673
New Hampshire	2,089	2,220	2,649	2,459	2,523	2,336	2,744
New Jersey	28,622	31,985	41,103	50,342	51,155	57,785	58,890
New Mexico	1,160	1,907	2,891	3,537	3,750	4,838	4,121
New York	56,588	47,790	68,622	68,705	79,148	82,512	102,115
North Carolina	7,714	11,774	18,795	20,878	23,531	27,803	33,249
North Dakota	1,379	1,542	2,011	2,353	2,660	3,118	3,517
Ohio	21,974	30,494	33,403	39,918	47,585	59,246	66,866
Oklahoma	1,260	2,254	3,648	5,603	6,559	7,219	7,143
Oregon	12,977	13,305	12,645	12,217	14,123	15,297	14,744
Pennsylvania	33,190	37,381	47,135	57,897	62,791	74,460	77,883
Puerto Rico	439	717	917	1,211	1,525	1,730	1,803
Rhode Island	3,438	3,624	4,217	4,967	5,126	5,901	6,157
South Carolina	3,065	4,437	6,015	8,745	7,720	10,544	13,218
South Dakota	1,137	1,225	2,175	2,111	2,305	2,678	2,966
Tennessee	3,871	3,519	5,567	6,467	5,868	9,757	12,086
Texas	6,370	8,308	10,879	13,246	15,959	17,619	19,703
Utah	5,442	8,133	11,643	11,591	11,441	12,140	11,733
Vermont	1,201	1,939	2,626	2,668	3,162	3,641	4,183
Virginia	9,081	8,737	11,758	12,027	13,930	212	243
Virgin Islands	143	150	140	159	211	13,687	15,536
Washington	18,319	19,244	26,495	29,173	32,021	33,483	38,429
West Virginia	1,430	2,201	3,311	3,868	4,544	5,344	5,647
Wisconsin	26,044	33,029	39,582	44,522	48,721	53,634	57,468
Wyoming	379	536	790	855	793	1.280	1,490
Nationwide total	596,532	670,637	879,862	1,000,147	1,089,798	1,225,485	1,358,907

[1] Preliminary data as of February 11, 1988.

Source: Office of Child Support Enforcement.

TABLE 8.—TOTAL NON-AFDC COLLECTIONS, SELECTED FISCAL YEARS 1979–87

[In thousands of dollars]

State	1979	1981	1983	1984	1985	1986	1987 [1]
Alabama	16	698	854	3,199	10,669	18,045	24,926
Alaska	3,510	5,159	7,924	8,579	8,736	10,035	12,897
Arizona	5,769	7,534	9,104	12,081	11,238	11,005	15,309
Arkansas	1,494	2,172	2,808	2,625	3,670	6,782	7,496
California	82,412	100,989	117,623	133,805	151,072	164,155	196,730
Colorado	496	7,797	7,848	6,143	8,952	7,920	11,221
Connecticut	11,617	13,918	18,599	21,215	24,604	28,397	30,779
Delaware	4,428	4,943	5,821	6,257	6,850	8,245	9,721
District of Columbia	179	530	1,100	1,751	2,083	2,416	2,778
Florida	1,926	4,643	8,672	12,165	19,490	34,934	48,248
Georgia	783	863	2,084	3,770	7,013	13,820	22,838
Guam	(1)	32	131	189	152	214	327
Hawaii	2,606	4,420	5,605	5,783	6,480	6,653	10,287
Idaho	454	617	884	857	1,490	6,151	8,457
Illinois	823	1,596	13,054	18,461	26,594	40,255	50,917
Indiana	957	2,210	3,142	3,508	9,098	17,309	22,837
Iowa	2,363	6,304	9,701	10,621	10,492	14,542	21,140
Kansas	520	1,629	2,114	2,769	1,648	6,118	10,044
Kentucky	266	10,418	13,387	15,977	15,704	16,757	20,780
Louisiana	7,434	10,404	16,113	17,080	21,216	25,476	24,250
Maine	441	945	1,833	2,356	3,593	4,935	6,864
Maryland	9,927	19,281	49,356	52,435	55,609	64,208	61,623
Massachusetts	7,193	14,712	31,844	41,140	51,996	58,914	74,846
Michigan	172,039	218,092	176,105	198,650	229,254	299,221	403,629
Minnesota	6,861	9,698	19,184	23,551	28,045	34,968	43,645
Mississippi	106	226	343	399	2,088	5,870	7,832
Missouri	1,664	5,941	6,618	10,486	17,542	36,269	36,957
Montana	528	659	582	621	711	1,193	1,963
Nebraska	385	7,810	16,369	19,934	24,043	28,390	31,507
Nevada	2,970	3,132	3,731	4,682	5,549	6,117	7,172
New Hampshire	0	116	8,972	9,425	10,248	11,867	14,798
New Jersey	65,383	72,868	102,122	133,030	149,000	171,785	186,808
New Mexico	520	841	1,722	1,986	2,542	3,141	4,552
New York	79,773	93,880	105,831	113,836	120,402	139,441	167,103
North Carolina	1,454	5,422	12,035	16,414	21,511	27,578	36,646
North Dakota	344	394	712	1,019	986	1,548	1,966
Ohio	858	972	1,459	1,652	35,115	65,499	113,830
Oklahoma	566	970	1,585	1,942	2,674	5,758	9,222
Oregon	75,525	92,364	25,406	25,184	25,655	33,853	38,726
Pennsylvania	153,528	185,167	238,694	269,766	308,372	340,342	377,301
Puerto Rico	1,477	1,742	31,068	84,000	52,740	57,482	64,360
Rhode Island	137	148	2,979	2,943	3,508	4,565	5,759
South Carolina	480	886	1,446	2,332	3,342	11,213	20,363
South Dakota	270	543	672	621	848	1,796	3,218
Tennessee	5,105	6,626	13,510	15,828	17,694	21,633	26,321
Texas	1,837	3,325	7,062	11,758	14,353	25,589	41,481
Utah	1,183	1,577	1,952	3,075	5,317	10,177	13,032
Vermont	249	260	202	211	522	996	1,598
Virginia	116	1,167	1,858	1,927	2,347	1,825	2,777
Virgin Islands	116	278	544	1,320	2,128	10,924	43,323
Washington	8,699	12,512	15,148	16,861	24,808	27,668	33,891
West Virginia	162	147	123	109	147	357	4,076
Wisconsin	8,224	9,165	16,459	20,912	33,350	67,627	97,233
Wyoming	141	245	227	398	437	1,231	1,739
Nationwide total	736,315	958,291	1,144,322	1,377,641	1,603,730	2,023,205	2,538,144

[1] Preliminary data as of February 11, 1988.

Source: Office of Child Support Enforcement.

TABLE 9.—AVERAGE NUMBER OF AFDC CHILD SUPPORT ENFORCEMENT CASES IN WHICH A COLLECTION WAS MADE, SELECTED FISCAL YEARS 1978–87

State	1978	1979	1981	1983	1984	1985	1986	1987 [1]
Total	458,439	463,100	547,707	594,679	646,545	684,114	581,571	604,370
Alabama	7,966	21,489	18,398	16,301	15,166	9,133	11,405	11,572
Alaska	246	213	613	1,154	1,180	1,120	933	1,038
Arizona	819	906	1,094	1,164	1,813	1,851	1,374	1,470
Arkansas	2,509	2,641	3,019	3,683	4,591	5,207	5,181	5,506
California	92,325	76,460	86,859	86,277	91,956	103,742	82,277	76,170
Colorado	3,177	2,875	3,322	4,129	5,096	5,687	3,723	4,092
Connecticut	8,002	9,078	11,245	13,591	14,600	15,565	16,013	13,337
Delaware	1,156	1,704	2,313	2,254	2,684	2,891	3,013	2,858
District of Columbia	708	758	848	1,508	1,999	1,925	2,067	2,138
Florida	7,376	6,710	9,837	11,856	15,596	16,468	16,310	16,489
Georgia	6,350	6,023	7,360	7,826	8,964	6,657	8,568	10,710
Guam	(2)	(2)	102	186	193	206	198	197
Hawaii	1,757	1,869	2,319	2,718	3,126	4,622	2,197	3,175
Idaho	1,346	1,166	1,122	936	2,482	4,343	1,106	1,245
Illinois	9,624	10,348	13,717	15,551	17,622	18,299	13,997	14,352
Indiana	9,488	6,339	8,226	19,514	22,553	22,058	11,287	16,188
Iowa	8,396	9,684	11,245	10,135	12,232	11,871	7,206	7,015
Kansas	2,859	2,842	3,764	4,205	4,901	4,769	3,200	3,798
Kentucky	3,083	3,341	4,638	4,601	5,171	6,729	5,988	6,853
Louisiana	5,204	5,461	6,652	6,944	6,978	7,836	8,930	9,916
Maine	2,368	3,043	4,297	6,141	6,970	7,178	4,437	4,734
Maryland	14,002	12,840	15,063	15,576	15,796	15,861	15,074	9,073
Massachusetts	17,782	19,357	22,147	22,655	23,482	25,350	10,015	17,211
Michigan	61,985	66,270	70,851	73,442	74,189	59,049	45,120	58,364
Minnesota	9,818	9,145	13,854	12,891	13,933	14,872	13,497	12,442
Mississippi	1,846	2,033	2,757	3,216	3,627	3,742	3,530	4,544
Missouri	(3)	3,550	5,048	2,465	2,280	7,716	5,979	6,483
Montana	748	540	726	1,178	1,385	1,600	1,092	849
Nebraska	1,509	1,333	1,559	1,841	2,217	2,362	2,961	2,555
Nevada	494	492	1,976	2,261	2,245	2,370	2.201	1,645
New Hampshire	1,530	1,710	2,093	1,512	1,169	1,021	749	981
New Jersey	16,243	31,161	28,663	24,712	29,751	27,686	23,354	25,182
New Mexico	1,429	1,650	1,772	2,027	2,779	2,034	2,785	2,175
New York	36,287	37,914	36,450	44,168	46,386	48,979	43,338	38,196
North Carolina	11,232	(2)	10,621	12,089	13,104	14,216	43,232	17,089
North Dakota	759	772	1,074	1,193	1,460	1,656	898	1,130
Ohio	24,419	20,456	26,097	26,064	28,771	32,582	37,016	35,273
Oklahoma	1,101	724	2,052	2,487	3,223	3,543	4,019	1,468
Oregon	6,761	6,771	6,330	4,020	6,202	6,687	6,016	5,935
Pennsylvania	15,172	13,376	22,406	35,405	39,565	42,088	48,960	48,817
Puerto Rico	413	636	2,044	2,281	2,683	3,736	3,458	3,588
Rhode Island	2,419	2,698	3,176	2,441	3,133	3,233	2,241	3,092
South Carolina	3,343	(2)	4,091	4,182	5,571	5,785	6,008	10,495
South Dakota	1,087	983	1,016	1,223	1,279	1,532	1,492	1,887
Tennessee	4,705	4,674	6,099	6,642	7,273	8,336	8,959	9,430
Texas	5,446	5,641	5,370	4,099	4,674	5,652	8,353	9,167
Utah	3,784	3,857	4,663	5,346	5,686	5,209	3,313	3,627
Vermont	953	1,057	1,778	2,223	2,167	2,329	1,547	1,984
Virgin Islands	232	145	115	82	121	199	222	220
Virginia	4,729	2,802	9,059	13,554	13,815	13,054	12,189	10,813
Washington	14,860	14,184	15,078	14,160	15,900	15,895	15,204	18,110
West Virginia	1,430	1,721	1,829	2,044	2,247	2,331	2,463	2,107
Wisconsin	16,868	21,391	20,514	26,106	24,166	44,799	23,720	26,847
Wyoming	294	267	346	420	393	453	656	738

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[1] Preliminary data as of February 11, 1988.

[2] Data not reported for this item or insufficient data reported to perform indicated computation.

Source: Office of Child Support Enforcement.

TABLE 10.—AVERAGE NUMBER OF NON-AFDC CHILD SUPPORT ENFORCEMENT CASES IN WHICH A COLLECTION WAS MADE, SELECTED FISCAL YEARS 1978–87

State	1978	1979	1981	1983	1984	1985	1986	1987[1]
Total	248,590	223,809	325,280	507,031	547,173	653,803	785,706	930,554
Alabama	110	50	26	221	893	5,023	11,133	11,583
Alaska	2,309	2,008	1,967	3,035	3,260	3,205	2,564	3,184
Arizona	(2)	3,478	0	5,525	5,148	4,770	4,250	4,668
Arkansas	764	1,521	2,137	2,803	3,194	3,613	4,048	5,074
California	69,696	54,019	56,803	66,164	63,650	64,686	71,357	78,395
Colorado	1,017	780	2,963	3,647	2,260	3,976	3,187	4,537
Connecticut	(2)	0	0	7,826	8,484	9,392	9,808	9,884
Delaware	3,210	3,104	3,302	3,611	3,788	4,395	4,212	5,073
District of Columbia	93	43	200	478	900	1,007	1,116	1,264
Florida	1,200	2,101	1,941	8,002	3,581	7,593	7,434	13,008
Georgia	1,207	1,451	2,018	4,091	6,001	5,487	8,284	14,883
Guam	(2)	0	39	63	81	65	86	114
Hawaii	(2)	0	261	308	321	352	3,926	2,804
Idaho	455	314	435	591	586	1,047	1,613	2,529
Illinois	196	1,260	3,423	6,433	6,603	10,030	12,171	14,479
Indiana	450	675	1,209	1,784	1,972	2,881	8,578	12,759
Iowa	671	1,460	3,419	4,192	4,240	4,913	5,095	3,441
Kansas	210	320	945	1,449	1,668	758	3,095	5,260
Kentucky	255	1,667	2,076	3,657	3,836	3,647	9,091	15,549
Louisiana	6,866	965	7,706	9,517	9,987	10,636	11,940	11,695
Maine	638	296	196	296	933	1,496	3,056	3,862
Maryland	130	0	6,186	27,384	26,232	26,154	30,875	12,685
Massachusetts	(2)	0	0	0	0	0	22,226	26,549
Michigan	(2)	0	0	51,304	50,131	88,675	84,397	126,187
Minnesota	2,766	3,866	5,707	10,263	11,155	12,615	14,067	16,137
Mississippi	81	153	248	320	456	1,319	2,742	4,348
Missouri	(2)	913	1,754	1,631	1,754	5,362	10,001	14,676
Montana	444	301	329	348	348	344	470	800
Nebraska	176	181	2,432	4,942	7,122	7,874	9,108	10,540
Nevada	4,026	2,558	4,650	4,084	4,758	5,360	3,929	3,212
New Hampshire	(2)	0	0	5,433	5,036	4,939	3,926	5,474
New Jersey	20,000	13,295	29,130	38,557	44,345	45,868	53,091	51,706
New Mexico	286	875	1,035	1,806	1,624	2,249	1,637	2,462
New York	39,623	37,854	48,370	54,296	60,471	63,829	66,234	76,630
North Carolina	1,715	0	3,190	5,910	7,800	10,137	11,744	15,323
North Dakota	154	149	99	171	221	266	653	865
Ohio	1,430	1,033	1,857	4,594	7,756	10,853	27,315	39,114
Oklahoma	(2)	184	719	1,269	1,400	1,968	2,977	4,867
Oregon	17,957	28,807	32,472	16,262	16,520	19,331	18,467	20,620
Pennsylvania	49,621	37,877	66,691	92,084	104,449	108,498	123,878	122,073
Puerto Rico	710	178	6,846	17,908	22,916	26,873	28,051	30,490
Rhode Island	57	110	294	1,407	1,941	1,969	2,059	2,750
South Carolina	203	0	472	1,198	1,348	2,777	2,706	3,165
South Dakota	297	254	391	512	516	502	1,144	2,175
Tennessee	6,360	7,816	6,251	10,271	11,032	12,156	13,001	14,957
Texas	2,861	1,673	2,744	4,224	4,575	8,833	9,595	15,079
Utah	400	427	489	698	889	1,068	2,750	4,008
Vermont	181	194	194	194	153	393	570	967
Virgin Islands	1	64	188	262	925	1,288	1,188	1,252
Virginia	38	36	1,078	1,554	916	876	5,689	19,273
Washington	4,822	5,115	6,215	7,422	8,824	9,802	10,456	13,656
West Virginia	130	147	185	186	125	288	157	1,953
Wisconsin	4,685	4,150	3,876	6,719	9,303	20,288	34,146	41,953
Wyoming	89	87	122	125	146	77	413	563

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[1] Preliminary data as of February 11, 1988.

[2] Data not reported for this item or insufficient data reported to perform indicated computation.

Source: Office of Child Support Enforcement.

TABLE 11.—NUMBER OF FAMILIES REMOVED FROM AFDC DUE TO CHILD SUPPORT COLLECTIONS, SELECTED FISCAL YEARS 1978–87

State	1978	1979	1981	1983	1984	1985	1986	1987[1]
Total	18,744	27,480	45,631	26,194	41,062	33,897	287,359	189,543
Alabama	1,048	284	135	2,011	968	324	425	480
Alaska	(2)	398	150	220	40	13	220	581
Arizona	118	17	31	10	0	0	0	0
Arkansas	824	215	297	308	159	109	3,128	3,973
California	(2)	0	0	0	88	445	8,714	17,433
Colorado	1,419	288	172	0	2,629	618	1,196	1,648
Connecticut	(2)	640	209	196	228	667	383	594
Delaware	(2)	128	0	94	62	54	0	0
District of Columbia	7	11	53	0	75	0	0	0
Florida	434	356	582	457	819	305	0	0
Georgia	(2)	272	0	37	1,302	1,600	3,118	5,427
Guam	(2)	0	15	69	0	0	10	23
Hawaii	29	0	27	189	114	140	104	161
Idaho	66	80	480	55	8	38	827	723
Illinois	718	0	0	546	765	615	1,571	4,923
Indiana	(2)	0	5,770	0	863	154	12,282	5,124
Iowa	(2)	780	41	23	78	21	1,516	1,620
Kansas	1,770	1,197	483	89	270	194	1,836	2,112
Kentucky	(2)	0	436	375	287	257	1,282	2,189
Louisiana	(2)	796	1,022	732	767	645	610	221
Maine	(2)	0	650	572	167	197	1,839	2,213
Maryland	1,848	1,184	970	648	1,074	0	3,583	2,744
Massachusetts	(2)	206	0	370	664	1,258	[3] 144,934	8,655
Michigan	209	1,417	1,639	1,008	1,059	570	445	489
Minnesota	582	490	1,146	815	1,459	808	5,175	5,458
Mississippi	47	0	86	0	23	68	1,622	1,514
Missouri	(2)	96	952	0	0	0	48,068	53,355
Montana	138	141	82	29	90	53	52	41
Nebraska	96	72	46	3	7	23	21	8
Nevada	(2)	0	106	138	80	79	126	115
New Hampshire	34	0	0	0	0	28	18	0
New Jersey	2,007	2,218	3,155	2,573	4,450	4,386	7,006	10,150
New Mexico	123	7	66	47	20	51	174	90
New York	(2)	2,050	2,495	3,318	5,124	6,105	5,771	33,089
North Carolina	(2)	244	289	288	333	145	117	150
North Dakota	(2)	1,218	125	578	2,207	1,673	2,044	1,145
Ohio	(2)	243	584	501	338	226	131	135
Oklahoma	859	208	159	169	199	101	12,096	2,749
Oregon	3,144	3,654	478	243	205	113	88	94
Pennsylvania	(2)	2,713	0	905	1,390	665	6,784	7,954
Puerto Rico	113	64	260	556	2,399	1,032	13	12
Rhode Island	(2)	1,810	1,383	0	363	282	1,278	569
South Carolina	51	0	724	0	1,475	1,867	158	77
South Dakota	287	136	123	30	112	36	746	1,082
Tennessee	(2)	0	16,152	4,223	2,857	2,730	1,661	1,690
Texas	1,921	1,697	1,405	2,111	3,618	2,851	2,210	2,236
Utah	329	331	401	0	321	647	670	953
Vermont	(2)	0	0	0	0	0	348	1,321
Virgin Islands	(2)	5	1	0	0	1	5	64
Virginia	167	1,475	524	0	77	111	107	1,174
Washington	(2)	0	0	0	0	0	506	1,388
West Virginia	270	250	1,383	932	775	689	509	485
Wisconsin	(2)	0	233	518	647	903	1,014	997
Wyoming	86	89	111	208	7	0	8	115

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[1] Preliminary data as of February 11, 1988

[2] Data not reported for this item or insufficient data reported to perform indicated computation.

[3] This number reflects a revised definition in Massachusetts for fiscal year 1986.

Note: These data are maintained by IV–A agencies, which often results in reporting difficulties for IV–D agencies. Also, 1986 data was reported using a new definition. This data represents IV–A cases closed when a child support payment was received.

Source: Office of Child Support Enforcement.

TABLE 12.—TOTAL NUMBER OF PATERNITIES ESTABLISHED, SELECTED FISCAL YEARS 1978–87

State	1978	1979	1981	1983	1984	1985	1986	1987 [1]
Total	110,714	137,645	163,538	208,270	219,360	231,838	244,996	255,097
Alabama	6,160	6,161	4,884	4,833	4,921	6,750	6,727	6,998
Alaska	5	3	73	105	90	84	252	364
Arizona	287	154	542	595	500	495	986	1,009
Arkansas	3,745	2,586	677	1,489	1,911	2,941	7,144	5,326
California	14,188	19,364	22,791	21,714	24,378	23,820	25,118	28,081
Colorado	1,137	1,046	1,103	1,033	1,187	1,426	1,451	1,291
Connecticut	2,566	3,029	3,769	4,563	4,363	4,622	4,579	3,908
Delaware	242	205	694	1,346	929	1,120	1,986	1,867
District of Columbia	378	386	907	811	471	583	664	1,021
Florida	6,684	7,078	7,557	10,679	15,741	14,452	14,358	12,759
Georgia	2,527	3,642	5,329	6,102	6,518	5,809	12,323	14,112
Guam	(2)	(2)	297	173	115	170	128	122
Hawaii	726	854	794	1,181	888	688	836	1,061
Idaho	40	287	79	84	205	383	299	384
Illinois	1,351	3,025	6,028	7,339	4,711	7,035	10,820	20,848
Indiana	2,052	1,644	1,287	3,036	6,859	5,149	3,580	3,570
Iowa	(2)	575	1,373	922	1,072	1,366	1,853	1,664
Kansas	521	696	1,141	682	404	325	528	1,119
Kentucky	367	784	2,157	2,986	2,774	3,315	3,464	3,881
Louisiana	1,013	1,304	2,869	3,195	3,180	4,235	4,234	2,926
Maine	(2)	382	339	604	554	809	570	951
Maryland	6,294	13,307	10,435	8,211	8,290	9,263	8,167	6,671
Massachusetts	1,218	2,096	3,564	3,766	3,841	5,208	2,513	7,025
Michigan	6,567	7,529	10,696	17,374	13,875	16,186	17,737	18,274
Minnesota	1,249	1,786	2,526	2,994	3,090	3,265	3,646	3,856
Mississippi	819	932	1,725	1,797	2,139	2,600	1,964	1,840
Missouri	(2)	(2)	476	17,522	17,046	14,423	10,208	0
Montana	68	92	97	37	33	54	120	179
Nebraska	(2)	(2)	268	410	449	430	461	710
Nevada	214	233	395	409	356	477	503	531
New Hampshire	42	35	71	30	52	13	76	195
New Jersey	7,503	8,242	11,282	10,616	11,739	13,853	13,731	13,938
New Mexico	170	322	1,258	1,141	970	709	838	412
New York	16,025	17,503	12,041	15,884	17,403	16,595	16,929	18,446
North Carolina	5,129	6,592	6,728	7,368	7,185	9,307	10,014	9,916
North Dakota	280	293	328	440	488	530	830	1,134
Ohio	2,305	4,808	7,658	7,767	9,804	9,314	10,057	9,133
Oklahoma	32	43	698	1,811	562	590	430	512
Oregon	1,528	1,521	2,199	2,173	1,947	2,189	2,351	1,902
Pennsylvania	4,811	4,450	7,305	11,906	13,404	15,613	17,443	15,164
Puerto Rico	25	22	38	19	12	5	22	6
Rhode Island	(2)	347	354	451	549	244	98	601
South Carolina	1,055	1,378	1,536	2,552	3,879	3,479	2,538	3,994
South Dakota	104	60	137	172	227	300	426	552
Tennessee	5,077	5,003	5,669	6,592	6,217	6,863	7,021	7,666
Texas	215	202	1,822	1,085	769	833	900	684
Utah	166	487	1,076	1,546	1,669	1,418	1,103	1,292
Vermont	77	44	245	349	379	388	688	1,091
Virgin Islands	1	4	3	104	15	146	106	235
Virginia	846	1,452	1,995	2,351	1,990	1,962	2,039	2,667
Washington	291	656	981	1,700	1,905	2,187	2,018	4,066
West Virginia	155	156	482	467	378	223	194	288
Wisconsin	4,440	4,803	4,672	5,688	6,895	7,384	7,812	8,750
Wyoming	19	44	88	66	32	210	113	105

[1] Preliminary data as of February 11, 1988.

[2] Data not reported for this item or insufficient data reported to perform indicated computation.

Source: Office of Child Support Enforcement.

TABLE 13.—TOTAL NUMBER OF SUPPORT OBLIGATIONS ESTABLISHED, SELECTED FISCAL YEARS 1978–87

State	1978	1979	1981	1983	1984	1985	1986	1987 [1]
Total	314,584	349,122	414,053	496,294	573,313	668,942	730,560	812,240
Alabama	8,545	7,585	5,137	6,766	11,615	17,781	11,476	12,182
Alaska	178	553	955	1,197	1,145	1,311	2,026	2,376
Arizona	(2)	686	2,993	3,069	2,145	2,761	2,587	2,385
Arkansas	6,277	3,382	3,484	3,519	4,666	5,698	12,704	9,070
California	51,752	61,806	63,323	54,598	56,528	54,310	54,651	49,399
Colorado	5,553	4,996	6,560	6,356	4,204	5,576	4,599	4,034
Connecticut	27,858	11,123	12,474	16,272	10,115	8,389	9,398	6,632
Delaware	247	276	1,814	1,709	1,406	1,953	3,669	3,340
District of Columbia	468	416	550	357	879	701	732	1,236
Florida	13,742	11,560	13,778	18,098	16,686	21,037	28,339	28,811
Georgia	4,443	5,739	7,372	9,551	9,894	8,687	12,323	14,747
Guam	(2)	(2)	169	132	81	146	105	152
Hawaii	2,585	1,748	2,069	3,351	3,297	3,234	2,434	2,251
Idaho	899	9,444	3,965	763	648	261	696	1,023
Illinois	16,512	11,379	10,933	22,850	19,198	20,819	19,455	21,278
Indiana	3,471	2,314	12,719	12,282	12,556	12,307	15,788	23,750
Iowa	(2)	4,204	10,752	8,490	10,701	7,358	8,725	8,264
Kansas	5,301	2,781	2,600	1,636	1,823	1,800	1,896	2,235
Kentucky	516	1,590	5,718	4,826	6,181	6,048	7,639	9,284
Louisiana	2,094	4,587	7,678	9,483	23,617	21,419	15,155	16,553
Maine	(2)	1,115	3,109	3,374	3,657	4,093	4,891	5,217
Maryland	10,341	8,128	10,100	9,238	22,818	27,592	32,797	36,902
Massachusetts	10,154	9,758	12,414	9,196	9,806	11,950	17,887	40,477
Michigan	6,123	7,572	10,445	15,436	24,826	35,416	57,845	84,492
Minnesota	1,747	4,095	8,268	6,626	10,243	10,130	9,798	8,372
Mississippi	720	730	822	861	1,680	3,065	2,418	1,895
Missouri	(2)	(2)	3,719	12,110	25,053	51,918	38,520	21,194
Montana	139	78	69	486	625	881	955	500
Nebraska	218	(2)	789	875	737	662	1,147	1,484
Nevada	1,889	1,579	4,362	3,883	3,858	3,339	3,405	4,106
New Hampshire	162	1,828	219	2,060	425	387	424	408
New Jersey	18,408	27,034	24,744	28,481	32,484	37,724	29,300	32,704
New Mexico	1,758	2,826	4,416	4,290	3,672	3,044	2,691	2,164
New York	25,098	28,379	27,987	37,131	45,144	43,733	51,063	47,840
North Carolina	4,282	10,577	11,473	12,584	12,467	17,277	18,764	16,859
North Dakota	589	571	443	528	647	523	878	1,162
Ohio	6,216	10,248	7,796	8,461	14,475	14,080	15,680	15,741
Oklahoma	624	1,770	3,824	3,747	4,549	4,113	4,793	3,752
Oregon	479	7,660	7,259	6,989	5,323	5,830	4,635	5,053
Pennsylvania	30,243	32,347	34,942	71,041	73,671	99,619	108,188	130,019
Puerto Rico	1,484	1,199	5,372	9,623	12,385	12,764	12,427	13,413
Rhode Island	(2)	2,391	2,835	4,514	2,517	2,322	3,046	2,607
South Carolina	1,065	924	1,272	1,928	5,862	4,747	3,613	6,117
South Dakota	1,735	(2)	338	516	516	653	1,035	1,690
Tennessee	2,603	3,408	4,149	7,307	9,234	10,742	13,045	16,536
Texas	12,171	12,066	11,784	13,523	10,437	12,461	31,671	32,881
Utah	4,520	3,582	4,794	6,251	7,894	6,551	5,331	5,217
Vermont	250	944	1,327	1,436	1,465	2,671	2,152	2,345
Virgin Islands	116	33	138	142	462	886	541	529
Virginia	969	2,407	7,949	5,223	3,913	7,594	7,785	19,509
Washington	10,340	9,546	9,211	10,948	9,416	9,961	7,767	10,312
West Virginia	349	382	728	558	686	700	464	843
Wisconsin	9,170	9,678	11,544	11,306	14,656	18,860	20,685	20,445
Wyoming	181	98	369	317	325	458	522	453

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[1] Preliminary data as of February 11, 1988.

[2] Data not reported for this item or insufficient data reported to perform indicated computation.

Source: Office of Child Support Enforcement.

TABLE 14.—PERCENTAGE OF AFDC ASSISTANCE PAYMENTS RECOVERED THROUGH CHILD SUPPORT COLLECTIONS, SELECTED FISCAL YEARS 1979–87

State	1979	1981	1983	1984	1985	1986	1987 [1]
Total	5.8	5.2	6.6	7.0	7.3	8.6	9.2
Alabama	8.5	6.5	10.6	12.0	21.0	21.2	23.2
Alaska	1.5	2.3	5.9	4.6	4.6	5.6	8.3
Arizona	2.0	2.6	2.3	3.2	2.5	3.5	5.1
Arkansas	4.8	5.3	13.3	13.3	15.2	16.6	17.6
California	6.5	4.0	4.6	4.8	4.5	5.7	6.1
Colorado	4.8	5.1	9.4	8.4	9.3	10.5	9.5
Connecticut	6.5	7.6	12.7	9.8	10.1	11.4	12.2
Delaware	4.4	6.2	8.4	12.7	14.6	16.3	17.3
District of Columbia	1.0	1.6	3.0	3.0	3.3	3.6	3.8
Florida	5.5	5.9	4.3	12.3	10.0	10.1	11.5
Georgia	4.3	5.0	6.0	7.5	9.8	9.3	10.4
Guam	5.3	3.0	6.1	6.2	6.4	6.0	9.1
Hawaii	2.9	3.4	5.3	5.4	6.6	7.6	8.9
Idaho	8.9	12.1	17.8	18.8	22.6	24.8	25.0
Illinois	1.5	1.6	2.3	2.9	3.2	4.0	4.8
Indiana	7.2	7.0	12.1	14.8	16.1	20.2	25.8
Iowa	9.0	10.3	13.5	14.2	15.0	18.2	19.6
Kansas	5.0	6.0	8.6	8.4	11.6	12.6	14.1
Kentucky	3.8	2.9	5.0	4.7	6.8	8.0	8.5
Louisiana	5.2	5.7	7.2	7.1	8.4	8.9	9.1
Maine	7.3	8.1	13.3	14.0	13.4	16.7	20.6
Maryland	6.1	7.0	12.4	10.6	11.6	12.9	12.7
Massachusetts	6.6	7.4	13.6	13.3	11.3	11.5	10.7
Michigan	9.0	7.9	8.6	8.8	9.7	12.8	12.5
Minnesota	7.8	8.4	10.0	10.0	10.5	13.1	12.7
Mississippi	2.9	3.7	8.0	8.5	7.9	8.1	9.4
Missouri	2.8	3.4	6.1	7.3	9.6	9.8	12.0
Montana	4.4	5.6	7.7	8.4	10.7	11.0	8.6
Nebraska	5.4	6.4	6.8	7.6	10.0	10.7	11.5
Nevada	6.3	7.1	16.8	17.3	14.9	18.3	16.4
New Hampshire	9.4	8.0	11.2	11.3	12.4	12.1	15.2
New Jersey	5.9	5.9	8.1	10.3	9.7	11.4	12.5
New Mexico	3.4	4.2	6.7	7.2	7.3	13.7	7.4
New York	3.5	3.2	3.9	3.6	4.0	4.3	5.0
North Carolina	5.6	7.5	16.3	14.1	15.0	15.2	17.4
North Dakota	9.6	9.8	13.5	14.6	14.7	15.8	16.8
Ohio	4.8	5.0	5.1	5.5	6.2	8.9	10.1
Oklahoma	1.6	2.5	4.7	6.6	7.5	7.2	6.4
Oregon	9.0	12.0	12.6	12.1	13.3	13.1	13.0
Pennsylvania	4.6	4.9	6.4	8.0	8.4	10.5	11.0
Puerto Rico	.7	1.1	2.9	1.8	2.4	2.8	2.7
Rhode Island	6.1	4.8	6.3	7.1	7.0	7.5	7.7
South Carolina	5.4	5.6	7.9	11.7	8.6	10.2	13.1
South Dakota	6.5	7.1	12.4	12.3	12.9	13.8	14.0
Tennessee	5.0	4.1	6.9	7.8	6.5	9.7	10.3
Texas	5.4	6.3	7.0	7.0	6.9	6.2	6.2
Utah	13.7	16.3	21.6	23.0	22.7	22.7	19.6
Vermont	4.1	5.0	7.2	6.7	8.4	10.4	11.1
Virgin Islands	8.5	5.3	4.7	5.0	7.6	7.7	8.4
Virginia	6.3	5.0	7.0	7.3	8.3	7.7	9.0
Washington	12.5	8.1	10.1	9.9	9.8	11.2	10.9
West Virginia	2.6	3.6	5.8	5.2	5.1	7.5	7.8
Wisconsin	9.5	8.7	8.8	8.5	8.8	11.5	12.4
Wyoming	5.6	6.3	7.1	7.3	5.5	8.8	8.2

[1] Preliminary data as of February 11, 1988.

Note: Payments to AFDC Unemployed Parent (UP) families have been excluded from the maintenance assistance payments totals in those States having AFDC–UP programs.

Source: Office of Child Support Enforcement.

TABLE 15.—FEDERAL INCOME TAX REFUND OFFSET PROGRAM COLLECTIONS, FISCAL YEARS 1982–87

State	1982	1983	1984	1985	1986	1987
Alabama	$829,981	$1,554,532	$2,438,075	$3,208,116	$4,158,370	$5,134,530
Alaska	113,964	211,588	302,922	364,352	730,773	891,177
Arizona		385,357	748,557	1,061,518	1,735,826	2,049,100
Arkansas	678,754	1,103,566	1,386,540	1,885,789	3,536,308	3,769,850
California	47,278,536	35,033,947	34,378,912	34,926,396	45,040,352	46,286,565
Colorado	1,318,097	3,016,164	2,771,764	2,392,575	3,096,581	3,020,479
Connecticut	6,589,307	4,455,263	4,193,916	4,223,787	5,696,890	6,140,042
Delaware	44,975	165,929	1,113,150	1,284,104	1,270,313	1,318,987
District of Columbia	586,913	566,848	694,106	746,926	761,360	778,803
Florida	47,460	1,979,829	2,932,974	3,937,836	5,782,072	7,317,971
Georgia	17,724	1,525,893	2,684,691	3,710,746	6,561,813	7,257,829
Guam		13,495	20,822	13,562		43,735
Hawaii	311,330	816,566	986,024	846,387	1,079,724	1,121,934
Idaho	1,492,980	1,183,105	1,199,305	1,203,527	1,428,403	1,593,848
Illinois	3,522,114	4,524,565	8,651,417	9,018,581	13,808,087	15,415,049
Indiana	1,278,354	4,939,883	8,537,166	8,975,438	11,780,348	11,389,957
Iowa	4,328,872	5,526,322	6,503,704	6,783,766	8,006,046	7,798,078
Kansas	2,685,617	2,525,333	2,634,443	2,904,537	3,460,795	3,703,519
Kentucky	2,168,561	1,165,135	2,043,980	2,298,529	3,099,365	3,261,918
Louisiana	1,426,863	1,536,006	1,958,915	2,487,475	4,443,087	4,722,260
Maine	664,374	1,844,168	2,114,258	2,126,207	2,483,995	3,377,197
Maryland	7,912,475	5,687,760	6,333,562	6,118,488	9,425,858	9,645,911
Massachusetts	2,139,366	3,324,872	2,992,203	4,224,674	4,759,597	5,269,023
Michigan	20,928,752	18,249,916	19,174,089	20,013,492	27,204,565	25,893,309
Minnesota	7,040,081	5,575,703	5,925,460	5,904,025	6,967,590	6,762,396
Mississippi	1,055,579	1,019,253	1,535,952	1,976,454	2,161,479	2,252,051
Missouri	6,467,902	4,288,944	4,607,125	4,849,186	7,124,967	8,481,658
Montana	177,985	431,107	610,862	857,855	1,151,151	1,209,404
Nebraska		501,968	784,106	1,204,572	1,240,436	1,395,395
Nevada	428,182	354,403	366,334	389,049	477,143	432,571
New Hampshire	474,129	756,639	545,252	662,364	1,346,108	1,283,608
New Jersey	9,348,364	9,458,355	10,232,231	11,449,337	13,831,313	14,267,810
New Mexico	206,602	533,226	702,254	1,315,407	1,719,059	2,277,767
New York	7,445,728	9,945,365	8,247,539	11,996,379	17,419,887	27,991,436
North Carolina	39,888	4,234,868	4,616,756	4,290,753	7,561,568	7,229,286
North Dakota	320,818	351,782	560,929	534,445	774,297	847,989
Ohio	649,865	2,885,540	5,145,031	7,229,010	8,705,343	11,185,599
Oklahoma	49,690	702,729	1,796,087	2,178,542	2,519,402	2,217,930
Oregon	7,069,119	3,782,458	3,520,661	3,566,932	5,479,093	4,862,510
Pennsylvania	2,304,759	6,112,433	13,567,884	13,549,899	17,430,478	17,123,072
Puerto Rico		1,742	22,852	13,047		13,408
Rhode Island	87,631	838,028	742,855	775,077	967,250	880,380
South Carolina	138,404	367,589	719,987	832,341	1,238,379	1,788,816
South Dakota	275,351	374,463	510,993	623,409	900,309	997,728
Tennessee	41,501	641,997	1,221,963	1,591,819	2,178,356	3,025,410
Texas		3,906,440	4,994,786	5,927,713	9,757,440	11,316,080
Utah	3,635,336	2,539,972	2,558,126	2,764,993	2,992,094	2,990,918
Vermont	1,245,080	611,431	590,943	748,212	946,258	886,590
Virgin Islands						36,999
Virginia	1,435,103	1,674,400	1,946,585	3,532,487	3,704,510	6,839,861
Washington	3,001,125	4,277,743	5,003,042	6,200,914	7,989,119	10,510,140
West Virginia	258,507	1,037,796	1,595,140	1,823,086	1,913,420	2,012,688
Wisconsin	8,340,059	6,265,914	5,102,546	7,973,405	9,597,270	10,029,403
Wyoming	165,555	221,757	191,272	280,427	387,739	503,122
Nationwide total	168,067,712	175,021,087	204,761,048	229,797,947	307,831,986	338,853,096

Source: Office of Child Support Enforcement.

TABLE 16.—ADMINISTRATIVE EXPENDITURES FOR THE CHILD SUPPORT ENFORCEMENT PROGRAM, SELECTED FISCAL YEARS 1979–87

[In thousands of dollars]

State	1979	1981	1982	1983	1984	1985	1986	1987 [1]
Alabama	4,633	5,637	7,089	9,132	10,757	12,786	13,273	14,878
Alaska	2,137	2,422	2,760	4,016	4,314	4,772	4,916	5,625
Arizona	2,014	4,659	3,415	5,891	6,550	5,996	9,397	9,096
Arkansas	2,385	3,657	4,722	4,539	4,796	5,252	5,670	5,532
California	75,579	100,807	112,766	127,171	123,947	131,625	141,939	156,472
Colorado	3,861	6,078	6,630	7,987	8,774	8,827	10,058	11,806
Connecticut	5,463	7,833	9,462	11,899	12,847	14,252	15,589	19,682
Delaware	852	2,512	2,066	3,299	2,105	1,903	4,965	4,519
District of Columbia	1,652	3,255	4,267	4,968	4,448	4,424	5,647	5,485
Florida	7,047	10,345	14,109	15,718	17,568	21,741	29,744	41,476
Georgia	3,238	4,777	7,089	8,208	10,299	11,793	13,624	15,200
Guam	108	161	223	315	319	296	351	411
Hawaii	1,408	2,708	3,094	3,705	4,338	4,902	5,227	5,157
Idaho	1,063	1,464	1,684	2,145	2,537	3,016	3,063	3,321
Illinois	6,930	14,622	16,627	16,320	18,589	25,515	30,256	35,746
Indiana	4,269	6,147	7,619	6,766	7,925	8,887	9,759	11,601
Iowa	4,239	5,808	6,231	5,930	5,821	5,805	5,987	7,925
Kansas	1,819	3,843	4,660	5,220	4,695	5,586	7,651	8,609
Kentucky	4,027	6,012	7,075	7,674	8,143	9,387	11,109	12,533
Louisiana	7,079	9,401	10,546	12,860	14,013	16,108	18,047	17,587
Maine	1,229	1,863	2,625	2,942	3,217	3,545	4,743	5,986
Maryland	8,177	13,973	13,886	16,355	18,484	21,739	25,365	32,384
Massachusetts	6,710	14,271	16,533	19,794	23,650	27,515	31,257	37,831
Michigan	24,614	30,364	36,575	41,365	44,523	44,750	50,979	55,923
Minnesota	9,273	12,937	16,407	17,358	17,760	20,249	22,796	22,656
Mississippi	1,574	1,965	2,402	2,936	2,986	3,411	5,155	4,590
Missouri	5,355	7,287	7,612	9,080	9,409	11,330	14,146	15,811
Montana	943	1,062	1,049	1,128	1,274	1,591	1,785	1,685
Nebraska	1,378	2,328	3,770	3,546	4,255	4,729	6,283	7,242
Nevada	1,891	3,023	3,130	3,437	3,364	3,572	4,269	4,286
New Hampshire	847	1,019	1,483	2,198	2,302	2,576	3,237	3,292
New Jersey	21,677	28,578	33,260	36,082	40,267	42,898	49,548	43,950
New Mexico	1,437	2,147	2,674	3,200	3,228	3,310	3,512	4,347
New York	61,665	63,658	77,830	86,437	89,777	101,862	121,400	137,481
North Carolina	5,721	8,705	11,150	12,293	14,059	15,314	17,000	18,234
North Dakota	702	1,024	1,210	1,246	1,458	1,591	1,893	2,071
Ohio	11,581	18,307	18,610	19,824	21,286	24,502	25,343	31,993
Oklahoma	2,771	4,896	6,128	6,117	5,548	6,336	7,297	7,384
Oregon	7,475	11,569	11,300	11,032	12,432	9,826	10,987	13,267
Pennsylvania	19,639	29,943	34,527	42,962	39,131	55,596	53,290	60,842
Puerto Rico	862	1,654	2,868	3,374	3,462	4,543	4,223	3,495
Rhode Island	1,079	1,584	2,033	2,141	2,354	2,456	2,685	3,569
South Carolina	1,777	2,215	2,353	2,887	4,445	6,511	9,189	11,150
South Dakota	1,060	1,026	1,175	1,198	1,173	1,335	1,630	2,118
Tennessee	3,046	5,504	6,420	7,041	7,026	8,175	9,482	12,507
Texas	11,733	14,256	16,492	15,071	14,124	13,960	21,522	23,522
Utah	3,094	4,982	5,629	6,789	7,308	8,609	10,085	10,379
Vermont	649	891	812	958	1,181	1,430	1,983	1,956
Virginia	4,787	7,038	7,645	7,668	8,029	8,801	15,698	861
Virgin Islands	483	323	217	319	424	715	954	26,363
Washington	10,733	11,826	13,300	16,979	18,934	22,941	25,291	28,293
West Virginia	1,676	2,404	2,962	2,550	2,613	2,830	2,873	4,870
Wisconsin	7,562	11,375	15,211	20,662	20,157	21,999	25,388	24,959
Wyoming	160	278	380	373	485	749	766	696
Nationwide total	383,163	526,423	611,792	691,106	722,910	814,165	941,252	1,058,650

[1] Preliminary data as of February 11, 1988.

Source: Office of Child Support Enforcement.

TABLE 17.—TOTAL CHILD SUPPORT COLLECTIONS PER DOLLAR OF TOTAL ADMINISTRATIVE EXPENDITURES, SELECTED FISCAL YEARS 1978–87

State	1978	1979	1981	1982	1983	1984	1985	1986	1987[1]
U.S. ratio	3.35	3.48	3.09	2.89	2.93	3.29	3.31	3.45	3.68
Alabama	.75	1.48	.89	1.14	.95	1.11	2.00	2.45	2.69
Alaska	3.19	1.80	2.45	2.68	2.42	2.39	2.26	2.61	3.05
Arizona	.88	3.18	1.88	3.05	1.79	2.18	2.15	1.46	2.21
Arkansas	1.00	1.64	1.33	1.18	1.63	1.63	1.90	2.62	2.94
California	2.15	2.65	2.00	2.19	2.00	2.31	2.32	2.37	2.52
Colorado	1.78	1.04	2.02	2.55	2.15	1.72	2.08	1.89	1.90
Connecticut	4.20	4.22	3.78	3.92	3.30	3.36	3.38	3.49	2.91
Delaware	7.14	6.82	2.76	3.57	2.45	4.64	5.62	2.46	3.07
District of Columbia	.73	.66	.59	.60	.71	.90	1.06	.92	1.04
Florida	1.20	1.49	1.64	1.44	1.21	2.43	2.10	2.12	1.97
Georgia	2.22	1.72	1.74	1.34	1.64	1.80	2.23	2.59	3.16
Guam		1.48	.92	1.16	1.24	1.52	1.46	1.39	1.53
Hawaii	1.71	3.66	2.79	2.66	2.72	2.37	2.38	2.26	3.10
Idaho	2.10	2.35	2.24	2.64	2.19	1.86	1.93	3.58	4.06
Illinois	2.10	1.55	.95	1.30	1.96	2.31	2.14	2.40	2.51
Indiana	2.42	2.13	2.01	1.91	3.07	3.29	3.79	4.82	5.22
Iowa	3.49	3.07	3.71	4.30	4.92	5.69	5.92	6.77	6.22
Kansas	3.01	2.19	1.80	2.06	1.90	2.32	2.05	2.15	2.58
Kentucky	1.14	1.21	2.45	2.07	2.57	2.75	2.68	2.52	2.59
Louisiana	1.82	1.79	1.90	2.12	2.00	1.96	2.13	2.21	2.28
Maine	3.40	3.72	3.05	2.84	3.48	3.75	3.98	3.74	3.75
Maryland	2.14	2.55	2.52	3.94	4.72	4.15	3.86	3.77	2.86
Massachusetts	5.12	5.42	3.71	3.85	3.65	3.55	3.57	3.50	3.40
Michigan	9.50	10.09	10.06	6.57	6.62	6.86	7.62	8.33	9.50
Minnesota	2.15	2.30	2.32	2.31	2.59	2.94	2.91	3.02	3.51
Mississippi	.87	1.06	1.28	1.12	1.66	1.77	2.02	2.29	3.36
Missouri	.89	1.09	1.70	2.44	2.00	2.64	3.24	3.89	3.83
Montana	1.58	1.29	1.60	1.67	2.14	2.27	2.46	2.59	3.16
Nebraska	2.10	1.79	4.65	4.54	5.65	5.69	6.32	5.44	5.20
Nevada	1.83	1.84	1.33	1.51	1.62	1.91	2.04	2.10	2.30
New Hampshire	4.05	2.47	2.29	3.12	5.29	5.16	4.96	4.39	5.33
New Jersey	4.16	4.37	3.67	3.96	3.97	4.55	4.67	4.64	5.59
New Mexico	1.17	1.17	1.28	1.30	1.44	1.71	1.90	2.27	1.99
New York	1.75	2.21	2.23	1.95	2.02	2.03	1.96	1.83	1.96
North Carolina	1.50	1.60	1.98	2.00	2.51	2.65	2.94	3.26	3.83
North Dakota	1.83	2.45	1.89	1.91	2.19	2.31	2.29	2.46	2.65
Ohio	2.50	1.97	1.72	1.66	1.76	1.95	3.38	4.41	5.65
Oklahoma	.76	.66	.66	.64	.86	1.36	1.46	1.78	2.22
Oregon	9.48	11.84	9.13	4.13	3.45	3.01	4.05	4.47	4.03
Pennsylvania	9.14	9.51	7.43	7.40	6.65	8.37	6.68	7.78	7.48
Puerto Rico	.92	2.22	1.49	6.06	9.48	24.61	11.95	14.02	18.93
Rhode Island	3.51	3.31	2.38	2.65	3.36	3.36	3.52	3.90	3.34
South Carolina	2.38	1.99	2.40	2.61	2.58	2.49	1.70	2.37	3.01
South Dakota	.99	1.33	1.72	1.81	2.38	2.33	2.36	2.74	2.92
Tennessee	2.49	2.95	1.84	2.72	2.71	3.17	2.88	3.31	3.07
Texas	.74	.70	.82	.84	1.19	1.77	2.17	2.01	2.60
Utah	1.99	2.14	1.95	2.12	2.00	2.01	1.95	2.21	2.39
Vermont	2.24	2.23	2.47	4.01	2.95	2.44	2.58	2.34	2.96
Virgin Islands	.40	.54	1.33	3.03	2.14	3.48	3.27	2.14	3.51
Virginia	.72	1.92	1.41	1.60	1.78	1.74	1.85	1.57	2.23
Washington	2.96	2.52	2.69	2.75	2.45	2.43	2.48	2.42	2.56
West Virginia	.74	.95	.98	.89	1.35	1.52	1.66	1.98	2.00
Wisconsin	3.80	4.53	3.71	2.84	2.71	3.25	3.73	4.78	6.20
Wyoming	3.18	3.25	2.81	2.31	2.72	2.58	1.64	3.27	4.64

[1] Preliminary data as of February 11, 1988.

Source: Office of Child Support Enforcement.

TABLE 18.—AFDC CHILD SUPPORT COLLECTIONS PER DOLLAR OF TOTAL ADMINISTRATIVE EXPENDITURES, FISCAL YEARS 1980–87

State	1980	1981	1982	1983	1984	1985	1986	1987 [1]
Alabama	1.22	0.89	1.14	0.85	0.82	1.16	1.09	1.01
Alaska	.26	.32	.38	.44	.40	.43	.57	.75
Arizona	.27	.26	.37	.25	.33	.27	.27	.53
Arkansas	.75	.73	.64	1.01	1.08	1.20	1.43	1.59
California	1.05	1.00	1.21	1.08	1.23	1.17	1.21	1.27
Colorado	.68	.74	.90	1.17	1.02	1.06	1.11	.94
Connecticut	2.05	2.00	2.25	1.73	1.71	1.66	1.67	1.34
Delaware	1.68	.80	.95	.69	1.66	2.02	.80	.92
District of Columbia	.48	.42	.42	.49	.50	.59	.49	53
Florida	1.11	1.19	1.01	.66	1.74	1.21	.95	.81
Georgia	1.38	1.56	1.14	1.38	1.44	1.63	1.50	1.66
Guam	.79	.72	.74	.82	.93	.95	.78	.73
Hawaii	1.41	1.15	1.08	1.21	1.03	1.05	.98	1.10
Idaho	1.99	1.82	2.02	1.77	1.53	1.43	1.57	1.52
Illinois	1.07	.84	1.02	1.16	1.31	1.09	1.07	1.08
Indiana	1.66	1.65	1.53	2.61	2.84	2.77	3.04	3.26
Iowa	2.69	2.62	2.91	3.29	3.87	4.11	4.34	3.56
Kansas	1.35	1.37	1.67	1.50	1.73	1.75	1.35	1.41
Kentucky	.82	.72	.53	.82	.78	1.01	1.01	.93
Louisiana	.86	.79	.88	.75	.74	.81	.80	.90
Maine	2.78	2.54	2.28	2.86	3.01	2.97	2.85	2.60
Maryland	1.27	1.14	1.09	1.70	1.31	1.30	1.24	.96
Massachusetts	3.12	2.68	2.44	2.04	1.81	1.68	1.61	1.43
Michigan	2.91	2.88	2.77	2.36	2.40	2.50	2.46	2.28
Minnesota	1.36	1.57	1.41	1.48	1.61	1.52	1.49	1.58
Mississippi	1.14	1.16	1.00	1.55	1.64	1.41	1.15	1.66
Missouri	.78	.88	1.63	1.27	1.52	1.69	1.32	1.49
Montana	.83	.98	1.18	1.63	1.78	2.01	1.92	2.00
Nebraska	1.56	1.30	.84	1.04	1.01	1.24	.93	.85
Nevada	.28	.29	.48	.53	.52	.48	.67	.62
New Hampshire	2.09	2.18	1.55	1.21	1.07	.98	.72	.83
New Jersey	1.24	1.12	1.01	1.14	1.25	1.19	1.17	1.34
New Mexico	.76	.89	.83	.90	1.10	1.13	1.38	.95
New York	.75	.75	.70	.79	.77	.78	.68	.74
North Carolina	1.29	1.35	1.15	1.53	1.49	1.54	1.64	1.82
North Dakota	1.68	1.51	1.46	1.61	1.61	1.67	1.65	1.70
Ohio	1.65	1.67	1.62	1.68	1.88	1.94	2.09	2.09
Oklahoma	.40	.46	.43	.60	1.01	1.04	.99	.97
Oregon	1.40	1.15	1.46	1.15	.98	1.44	1.39	1.11
Pennsylvania	1.35	1.25	1.18	1.10	1.48	1.13	1.40	1.28
Puerto Rico	.62	.43	.24	.27	.35	.34	.41	.52
Rhode Island	2.52	2.29	1.90	1.97	2.11	2.09	2.20	1.72
South Carolina	2.04	2.00	2.00	2.08	1.97	1.19	1.15	1.19
South Dakota	1.29	1.19	1.22	1.81	1.80	1.73	1.64	1.40
Tennessee	.92	.64	.92	.79	.92	.72	1.03	.97
Texas	.49	.58	.42	.72	.94	1.14	.82	.84
Utah	1.45	1.63	1.79	1.71	1.59	1.33	1.20	1.13
Vermont	1.87	2.18	3.74	2.74	2.26	2.21	1.84	2.14
Virgin Islands	.28	.47	.82	.44	.37	.29	.22	.28
Virginia	1.33	1.24	1.36	1.53	1.50	1.58	.87	.59
Washington	1.51	1.63	1.66	1.56	1.54	1.40	1.32	1.36
West Virginia	.96	.92	.84	1.30	1.48	1.61	1.86	1.16
Wisconsin	2.34	2.90	2.11	1.92	2.21	2.21	2.11	2.30
Wyoming	2.29	1.93	1.63	2.12	1.76	1.06	1.67	2.14
Nationwide total	1.30	1.27	1.28	1.27	1.38	1.34	1.30	1.28

[1] Preliminary data as of February 11, 1988.

Source: Office of Child Support Enforcement.

TABLE 19.—NON-AFDC CHILD SUPPORT COLLECTIONS PER DOLLAR OF TOTAL ADMINISTRATIVE EXPENDITURES, FISCAL YEARS 1980–87

State	1980	1981	1982	1983	1984	1985	1986	1987 [1]
Alabama	0.00	0.00	0.00	0.09	0.30	.83	1.36	1.68
Alaska	1.82	2.13	2.30	1.97	1.99	1.83	2.04	2.29
Arizona	1.81	1.62	2.69	1.55	1.84	1.87	1.17	1.68
Arkansas	.68	.59	.53	.62	.55	.70	1.20	1.35
California	1.10	1.00	.98	.92	1.08	1.15	1.16	1.26
Colorado	.40	1.28	1.65	.98	.70	1.01	.79	.95
Connecticut	1.99	1.78	1.67	1.56	1.65	1.73	1.82	1.56
Delaware	4.71	1.97	2.63	1.76	2.97	3.60	1.66	2.15
District of Columbia	.14	.16	.18	.22	.39	.47	.43	.51
Florida	.16	.45	.42	.55	.69	.90	1.17	1.16
Georgia	.18	.18	.20	.25	.37	.59	1.01	1.50
Guam	.01	.20	.42	.42	.59	.51	.61	.80
Hawaii	2.02	1.63	1.58	1.51	1.33	1.32	1.27	1.99
Idaho	.52	.42	.62	.41	.34	.49	2.01	2.55
Illinois	.11	.11	.28	.80	.99	1.04	1.33	1.42
Indiana	.26	.36	.39	.46	.44	1.02	1.77	1.97
Iowa	.69	1.09	1.40	1.64	1.82	1.81	2.43	2.67
Kansas	.31	.42	.39	.41	.59	.30	.80	1.17
Kentucky	2.26	1.73	1.54	1.74	1.96	1.67	1.51	1.66
Louisiana	1.07	1.11	1.23	1.25	1.22	1.32	1.41	1.38
Maine	.38	.51	.56	.62	.73	1.01	1.04	1.15
Maryland	1.28	1.38	2.85	3.02	2.84	2.56	2.53	1.90
Massachusetts	1.16	1.03	1.41	1.61	1.74	1.89	1.88	1.98
Michigan	7.96	7.18	3.80	4.26	4.46	5.12	5.87	7.22
Minnesota	.72	.75	.90	1.11	1.33	1.39	1.53	1.93
Mississippi	.10	.12	.12	.12	.13	.61	1.14	1.71
Missouri	.74	.82	.81	.73	1.11	1.55	2.56	2.34
Montana	.69	.62	.49	.52	.49	.45	.67	1.17
Nebraska	.30	3.35	3.70	4.62	4.68	5.08	4.52	4.35
Nevada	.98	1.04	1.02	1.09	1.39	1.55	1.43	1.67
New Hampshire	.08	.11	1.56	4.08	4.09	3.98	3.67	4.50
New Jersey	2.90	2.55	2.95	2.83	3.30	3.47	3.47	4.25
New Mexico	.34	.39	.47	.54	.62	.77	.89	1.05
New York	1.47	1.47	1.25	1.22	1.27	1.18	1.15	1.22
North Carolina	.28	.62	.85	.98	1.17	1.40	1.62	2.01
North Dakota	.43	.38	.45	.57	.70	.62	.82	.95
Ohio	.06	.05	.05	.07	.08	1.43	2.31	3.56
Oklahoma	.19	.20	.21	.26	.35	.42	.79	1.25
Oregon	8.15	7.98	2.68	2.30	2.03	2.61	3.08	2.92
Pennsylvania	6.70	6.18	6.22	5.56	6.89	5.55	6.39	6.20
Puerto Rico	1.56	1.05	5.82	9.21	24.26	11.61	13.61	18.42
Rhode Island	.10	.09	.74	1.39	1.25	1.43	1.70	1.61
South Carolina	.39	.40	.61	.50	.52	.51	1.22	1.83
South Dakota	.38	.53	.59	.56	.53	.64	1.10	1.52
Tennessee	1.55	1.20	1.81	1.92	2.25	2.16	2.28	2.10
Texas	.19	.23	.42	.47	.83	1.03	1.19	1.76
Utah	.31	.32	.33	.29	.42	.62	1.01	1.26
Vermont	.35	.29	.27	.21	.18	.37	.50	.82
Virgin Islands	.46	.86	2.21	1.70	3.11	2.97	1.91	3.22
Virginia	.08	.17	.24	.24	.24	.27	.70	1.64
Washington	.85	1.06	1.09	.89	.89	1.08	1.09	1.20
West Virginia	.07	.06	.05	.05	.04	.05	.12	.84
Wisconsin	.65	.81	.73	.80	1.04	1.52	2.66	3.90
Wyoming	.96	.88	.68	.61	.82	.58	1.61	2.50
Nationwide total	1.88	1.82	1.61	1.66	1.91	1.97	2.15	2.40

[1] Preliminary data as of February 11, 1988.

Source: Office of Child Support Enforcement.

TABLE 20.—CHILD SUPPORT COLLECTIONS PER DOLLAR OF ADMINISTRATIVE EXPENDITURES, FISCAL YEAR 1987

State	Total collections/ total expenditures	AFDC collections/total expenditures	Non-AFDC collections/total expenditures
U.S. total	3.68	1.28	2.40
Alabama	2.69	1.01	1.68
Alaska	3.05	0.75	2.29
Arizona	2.21	0.53	1.68
Arkansas	2.94	1.59	1.35
California	2.52	1.27	1.26
Colorado	1.90	0.94	0.95
Connecticut	2.91	1.34	1.56
Delaware	3.07	0.92	2.15
District of Columbia	1.04	0.53	0.51
Florida	1.97	0.81	1.16
Georgia	3.16	1.66	1.50
Guam	1.53	0.73	0.80
Hawaii	3.10	1.10	1.99
Idaho	4.06	1.52	2.55
Illinois	2.51	1.08	1.42
Indiana	5.22	3.26	1.97
Iowa	6.22	3.56	2.67
Kansas	2.58	1.41	1.17
Kentucky	2.59	0.93	1.66
Louisiana	2.28	0.90	1.38
Maine	3.75	2.60	1.15
Maryland	2.86	0.96	1.90
Massachusetts	3.40	1.43	1.98
Michigan	9.50	2.28	7.22
Minnesota	3.51	1.58	1.93
Mississippi	3.36	1.66	1.71
Missouri	3.83	1.49	2.34
Montana	3.16	2.00	1.17
Nebraska	5.20	0.85	4.35
Nevada	2.30	0.62	1.67
New Hampshire	5.33	0.83	4.50
New Jersey	5.59	1.34	4.25
New Mexico	1.99	0.95	1.05
New York	1.96	0.74	1.22
North Carolina	3.83	1.82	2.01
North Dakota	2.65	1.70	0.95
Ohio	5.65	2.09	3.56
Oklahoma	2.22	0.97	1.25
Oregon	4.03	1.11	2.92
Pennsylvania	7.48	1.28	6.20
Puerto Rico	18.93	0.52	18.42
Rhode Island	3.34	1.72	1.61
South Carolina	3.01	1.19	1.83
South Dakota	2.92	1.40	1.52
Tennessee	3.07	0.97	2.10
Texas	2.60	0.84	1.76
Utah	2.39	1.13	1.26
Vermont	2.96	2.14	0.82
Virgin Islands	3.51	0.28	3.22
Virginia	2.23	0.59	1.64
Washington	2.56	1.36	1.20
West Virginia	2.00	1.16	0.84
Wisconsin	6.20	2.30	3.90
Wyoming	4.64	2.14	2.50

TABLE 21.—INCENTIVE PAYMENTS TO STATES AND LOCALITIES FOR AFDC COLLECTIONS, SELECTED FISCAL YEARS 1979–87

[In thousands of dollars]

State	1979	1981	1982	1983	1984	1985	1986	1987[1]
Alabama	801	628	704	1,234	1,578	3,024	1,560	1,800
Alaska	7	113	158	245	219	278	393	432
Arizona	79	148	157	198	254	191	570	780
Arkansas	247	385	412	572	634	749	755	1,052
California	13,868	9,296	13,891	13,102	30,730	31,713	21,224	23,344
Colorado	407	755	914	1,337	1,077	1,121	1,383	1,685
Connecticut	440	2,325	3,117	2,977	2,551	2,906	3,688	3,530
Delaware	23	300	294	341	420	462	484	654
District of Columbia	11	169	223	267	356	297	410	486
Florida	445	2,080	1,871	2,108	3,315	3,453	3,660	4,936
Georgia	384	1,078	1,195	1,685	1,783	2,312	1,891	2,611
Guam	403	2	2	4	3	29	41	30
Hawaii	234	497	413	524	706	700	678	750
Idaho	6	428	463	471	447	499	669	806
Illinois	414	1,936	2,527	2,807	2,896	2,767	5,298	5,672
Indiana	943	1,502	1,401	2,424	2,570	2,976	3,897	5,830
Iowa	1,456	2,106	2,458	3,184	2,580	2,804	3,444	3,493
Kansas	255	770	1,082	1,103	905	1,100	1,164	1,623
Kentucky	552	666	502	896	760	1,072	1,336	1,550
Louisiana	731	1,181	1,202	1,503	1,241	1,461	1,236	1,808
Maine	61	699	892	1,250	1,154	1,253	1,612	1,692
Maryland	662	2,131	2,052	3,896	2,849	3,089	3,488	4,502
Massachusetts	46	5,597	6,071	6,046	5,202	5,573	7,042	7,980
Michigan	12,815	11,550	13,717	13,408	14,522	14,582	22,500	25,336
Minnesota	1,834	2,737	4,383	3,826	3,454	3,677	5,048	5,548
Mississippi	2	59	95	310	223	366	662	853
Missouri	586	888	1,816	1,622	1,609	1,883	2,208	2,796
Montana	20	153	182	274	277	363	269	295
Nebraska	265	419	423	538	505	691	808	842
Nevada	74	125	186	224	175	154	402	482
New Hampshire	29	343	349	374	281	291	340	372
New Jersey	4,070	4,681	4,877	6,037	6,325	5,887	7,190	7,526
New Mexico	21	282	333	434	424	450	363	517
New York	8,787	7,163	8,193	10,308	8,248	9,498	10,166	10,536
North Carolina	1,021	1,724	1,898	2,801	2,528	2,809	3,922	4,182
North Dakota	191	219	251	284	276	315	277	339
Ohio	3,295	4,574	4,512	5,010	4,790	5,710	5,341	8,850
Oklahoma	42	326	387	547	672	787	730	866
Oregon	296	1,845	2,388	1,839	1,572	1,624	2,114	2.168
Pennsylvania	4,701	5,399	5,670	6,577	7,122	6,788	8,076	9,166
Puerto Rico	4	73	92	127	136	167	224	270
Rhode Island	53	505	552	619	570	613	918	1,001
South Carolina	328	354	512	698	994	1,015	1,392	1,800
South Dakota	45	118	183	378	249	227	308	375
Tennessee	493	568	835	782	772	716	1,192	1,408
Texas	188	1,114	959	1,609	1,602	1,878	2,950	2,940
Utah	596	1,238	1,509	1,791	1,397	730	1,911	1,446
Vermont	22	289	453	392	319	379	374	504
Virgin Islands	1	23	25	21	19	25	26	30
Virginia	262	1,130	1,502	1,728	1,414	1,658	1,473	2,096
Washington	202	2,817	3,236	3,878	3,419	3,673	4,128	4,504
West Virginia	31	389	369	492	463	538	303	363
Wisconsin	3,905	4,945	4,655	5,417	4,993	4,986	6,428	9,888
Wyoming	5	69	86	117	103	90	107	170
Nationwide total	66,255	90,911	144,781	158,098	133,682	144,781	158,073	184,515

[1] Preliminary data as of February 11, 1988.

Source: Office of Child Support Enforcement.

TABLE 22.—OUT-OF-WEDLOCK BIRTHS AND IV–D PATERNITIES: 1985

State	Births to unmarried women, 1985	IV–D paternities established, 1985	1985 paternities/ 1985 births
Alabama	14,897	6,750	45.3
Alaska	2,344	84	3.6
Arizona	14,172	495	3.5
Arkansas	7,898	2,941	37.2
California	115,671	23,820	20.6
Colorado	9,158	1,426	15.6
Connecticut	9,358	4,622	49.4
Delaware	2,522	1,120	44.4
District of Columbia	5,598	583	10.4
Florida	42,202	14,452	34.2
Georgia	24,764	5,809	23.5
Hawaii	3,644	688	18.9
Idaho	1,893	383	20.2
Illinois	46,495	7,035	15.1
Indiana	16,020	5,149	32.1
Iowa	5,590	1,366	24.4
Kansas	5,843	325	5.6
Kentucky	9,799	3,315	33.8
Louisiana	23,261	4,235	18.2
Maine	3,012	809	26.9
Maryland	19,773	9,263	46.8
Massachusetts	15,033	5,208	34.6
Michigan	24,941	16,189	64.9
Minnesota	10,158	3,265	32.1
Mississippi	14,275	2,600	18.2
Missouri	16,599	14,423	[1] 86.9
Montana	2,270	54	2.4
Nebraska	3,790	430	11.3
Nevada	2,398	477	19.9
New Hampshire	2,065	13	0.6
New Jersey	23,495	13,853	59.0
New Mexico	7,298	709	9.7
New York	72,839	16,595	22.8
North Carolina	19,772	9,307	47.1
North Dakota	1,347	530	39.3
Ohio	34,992	9,314	26.7
Oklahoma	9,149	590	6.4
Oregon	7,403	2,189	29.6
Pennsylvania	36,546	15,613	42.7
Rhode Island	2,549	244	9.6
South Carolina	13,714	3,479	25.4
South Dakota	2,175	300	13.8
Tennessee	16,214	6,863	42.3
Texas	50,445	833	1.7
Utah	3,259	1,418	43.5
Vermont	1,378	388	28.2
Virginia	18,443	1,962	10.6
Washington	12,978	2,187	16.9
West Virginia	4,202	223	5.3
Wisconsin	13,359	7,384	55.3
Wyoming	1,244	210	16.9
United States total	828,174	231,838	28.0

[1] Figure might be overstated because of reporting errors.

Sources: National Center for Health Statistics, Monthly Vital Statistics Report, vol. 36, no. 4, Supplement, July 17, 1987, page 29; U.S. Department of Health and Human Services, Office of Child Support Enforcement, Eleventh Annual Report to Congress, page 46; and a letter from Robert G. Williams, Ph.D., Policy Studies, Inc., dated March 15, 1988.

Status of Implementation of the 1984 Child Support Enforcement Amendments

Public Law 98-378 requires States to implement a range of new enforcement techniques designed to improve the effectiveness of the child support enforcement program. Public Law 98-378 requires States to implement the requirements by October 1, 1985, unless a State requested and received an implementation delay to enact necessary legislation. In such cases, the effective date for that State would be the first day of the fourth month after the State legislature ended its first legislative session begun after the August 16, 1984 enactment date of the Amendments.

Tables 23 and 24, supplied by the Department of Health and Human Services, summarize the status of implementation of these requirements as of February 1, 1988.

In addition, HHS reports that 39 States have implemented all eight mandatory enforcement techniques plus the requirement for developing uniform guidelines for support. These States are:

Alabama
Alaska
Arizona
Arkansas
Connecticut
Delaware
Florida
Georgia
Idaho
Indiana
Iowa
Kansas
Louisiana
Maine
Michigan
Minnesota
Mississippi
Missouri
Montana
Nebraska
New Hampshire
New Jersey
New Mexico
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
Washington
West Virginia
Wisconsin

Seven States have implemented all eight mandatory enforcement techniques but have not developed the guidelines for support. These States are:

District of Columbia
Guam
Kentucky
Maryland
New York
Puerto Rico
Virgin Islands

Three States—Colorado, Massachusetts, and Pennsylvania—have been notified of HHS's intent to disapprove their State plans for lack of implementation of at least one of the requirements. All have requested a compliance hearing.

In addition, two States—Guam and Maryland—have been notified of HHS's intent to disapprove State plans for lack of implementation of the prohibition on retroactive modification of arrearages.

TABLE 23.—IMPLEMENTATION STATUS OF MANDATORY REQUIREMENTS OF 1984 CHILD SUPPORT ENFORCEMENTS (PUBLIC LAW 98–378)

[As of February 1, 1988]

Mandatory requirements	States with statutes addressing the requirement [1]	No law [2]	Exemption granted [3]	Requirement implemented [4]
Mandatory wage withholding	54	0	....	51
Expedited process [5]	54	0	....	48
State tax refund offset	44	10	10	43
Liens	54	0	1	53
Paternity statute	54	0	....	54
Security or bond	54	0	....	54
Consumer credit	54	0	....	53
Wage withholding in orders	54	0	....	53

[1] Coverage may be incomplete. Includes States having an exemption from passing legislation.

[2] State does not have an income tax.

[3] State has received a State-wide exemption from implementing the requirement.

[4] Includes States having an exemption to operate a similar existing procedure.

[5] Twenty-four States have exemptions to operate similar existing procedures in some of their political jurisdictions.

TABLE 24.—IMPLEMENTATION STATUS OF OTHER REQUIREMENTS OF 1984 CHILD SUPPORT ENFORCEMENT AMENDMENTS (PUBLIC LAW 98–378)

[As of February 1, 1988]

Other requirements	Implementation planned	Requirement implemented
Non-AFDC application fee	0	54
Notice to AFDC recipients	0	54
Late payment fees (optional)	0	4
Passthrough of incentive payments (optional for some States)	0	38
Continuation of services	0	54
Enforcement of foster care [1]	0	51
Spousal support	0	54
Services publicized	0	54
State commissions	0	[2] 42
Medical support in orders	2	52
Extension of Medicaid eligibility	0	54
Child support guidelines	7	47
Non-AFDC Federal tax offset	0	54

[1] Excludes Guam, Puerto Rico and the Virgin Islands.

[2] Commission report filed. Eleven waivers granted. One report, from the Virgin Islands, was not submitted to OCSE.

LEGISLATIVE CHANGES IN THE 99TH CONGRESS

During the second session of the 99th Congress, Public Law 99-509 was enacted. Titled the Omnibus Budget Reconciliation Act of 1986, the new law included one child support enforcement amendment prohibiting the retroactive modification of child support awards. Under this new requirement, State laws must provide for either parent to apply for modification of an existing order with notice provided to the other parent. No modification is permitted before the date of this notification.

LEGISLATIVE CHANGES IN THE 98TH CONGRESS

In November 1983, the House of Representatives adopted H.R. 4325, the Child Support Enforcement Amendments, which had been developed by the Subcommittee on Public Assistance and Unemployment Compensation and approved by the Committee on Ways and Means. In August 1984, the amendments were signed into law. The new law strengthens the child support enforcement and paternity establishment program. It requires States to implement effective enforcement tools and provides incentives to the States to make available services to both AFDC and non-AFDC families. The main provisions of the Child Support Enforcement Amendments of 1984 (P.L. 98-378) are summarized below:

1. Improved child support enforcement through requiring State laws and procedures.—States are required to enact laws establishing the following procedures with respect to their IV-D cases:

A. Mandatory wage withholding for all families (AFDC and non-AFDC) if support payments are delinquent in an amount equal to 1 month's support. States must also allow absent parents to request withholding at an earlier date.

B. Imposing liens against real and personal property for amounts of overdue support.

C. Withholding of State tax refunds payable to a parent of a child receiving IV-D services, if the parent is delinquent in support payments.

D. Making available information regarding the amount of overdue support owed by an absent parent, to any consumer credit bureau, upon request of such organization.

E. Requiring individuals who have demonstrated a pattern of delinquent payments to post a bond, or give some other guarantee to secure payment of overdue support.

F. Establishing expedited processes within the State judicial system or under administrative procedures for obtaining and enforcing child support orders, and, at the option of the State, for determining paternity.

G. Notifying each AFDC recipient at least once each year of the amount of child support collected on behalf of that recipient.

H. Permitting the establishment of paternity until a child's 18th birthday.

I. At the option of the State, providing that child support payments must be made through the agency that administers the State's income withholding system if either the custodial or noncustodial parent requests that they be made in this manner.

2. Federal matching of administrative costs.—The Federal matching share is gradually reduced from 70 percent as follows: 68 percent in fiscal years 1988 and 1989, and 66 percent in fiscal year 1990 and each year thereafter.

3. Federal incentive payments.—The prior incentive formula which gave States 12 percent of their AFDC collections (paid for out of the Federal share of the collections) is replaced with a new formula that is designed to encourage States to develop programs that emphasize collections on behalf of both AFDC and non-AFDC families, and to improve program cost effectiveness. The basic incentive payment will be equal to 6 percent of the State's AFDC collections, and 6 percent of its non-AFDC collections. States may qualify for higher incentive payments, up to a maximum of 10 percent of collections, if their AFDC or non-AFDC collections exceed combined administrative costs for both AFDC and non-AFDC components of the program.

The total dollar amount of incentives paid for non-AFDC families may not exceed the amount of the State's incentive payment for AFDC collections for fiscal years 1986 and 1987. However, thereafter the incentive paid for non-AFDC collections will be capped at an amount equal to 105 percent of the incentive for AFDC collections in fiscal year 1988, 110 percent in fiscal year 1989, and 115 percent in fiscal year 1990 and any fiscal year thereafter.

4. Matching for automated management systems used in income withholding and other procedures.—The Act specifies that the 90 percent Federal matching rate that is currently available to States that elect to establish an automatic data processing and information retrieval system may be used, at the option of the State, for the development and improvement of the income withholding and other procedures required in the new law through the monitoring of child support payments, the maintenance of accurate records regarding the payment of child support, and the provision of prompt notice to appropriate officials with respect to any arrearages that occur. Also, the Act specifies that the 90 percent matching is available to pay for the acquisition of computer hardware.

5. Fees for services to non-AFDC families.—States will be required to charge an application fee for non-AFDC cases not to exceed $25. The amount of the maximum allowable fee may be adjusted periodically by the Secretary to reflect changes in administrative costs. The State may charge the fee against the custodial parent, pay the fee out of State funds, or recover the fee from the noncustodial parent.

In addition, at the option of the State, a late payment fee equal to between 3 and 6 percent of the amount of overdue support may be charged to the noncustodial parents of AFDC and non-AFDC families. The State may not take any action which would have the effect of reducing the amount of support paid to the child and will collect the fee only after the full amount of the support has been paid to the child. The late payment fee provision is effective upon enactment.

6. Continuation of support enforcement for AFDC recipients whose benefits are being terminated.—States must provide that families whose eligibility for AFDC is terminated due to the receipt of (or an increase in) child support payments will be automatically transferred from AFDC to non-AFDC status under the IV-D program, without requiring application for IV-D services or payment of a fee.

7. Special project grants to promote improvement in interstate enforcement.—The Secretary is authorized to make demonstration grants to States which propose to undertake new or innovative methods of support collection in interstate cases. The authorization is $7 million in FY 1985, $12 million in FY 1986, and $15 million in FY 1987 and years thereafter.

8. Periodic review of State programs; modification of penalty.—The Director of the Federal Office of Child Support Enforcement is required to conduct audits at least every 3 years to determine whether the standards and requirements prescribed by law and regulations have been met. Under the penalty provision, a State's AFDC matching funds must be reduced by an amount equal to at least 1 but no more than 2 percent for the first failure to comply substantially with the standards and requirements, at least 2 but no more than 3 percent for the second failure, and at least 3 but no more than 5 percent for the third and any subsequent consecutive failures.

9. Extension of sec. 1115 demonstration authority to the child support program.—The sec. 1115 demonstration authority is expanded to include the child support enforcement program under specified conditions.

10. Child support enforcement for certain children in foster care.—State child support agencies are required to undertake child support collections on behalf of children receiving foster care maintenance payments under title IV-E, if an assignment of rights to support to the State has been secured by the foster care agency. In addition, foster care agencies are required to take steps, where appropriate, to secure an assignment to the State of any rights to support on behalf of a child receiving foster care maintenance payments under the title IV-E foster care program.

11. Collection of spousal support.—Child support enforcement services must include the enforcement of spousal support, but only if a support obligation has been established with respect to the spouse, the child and spouse are living in the same household, and child support is being collected along with spousal support.

12. Modification in content of annual report by the Secretary.—The present annual report information requirements are expanded to include data needed to evaluate State programs.

13. Requirement to publicize the availability of child support services.—States must frequently publicize, through public service announcements, the availability of child support enforcement services, together with information as to the application fee for such services and a telephone number or postal address to be used to obtain additional information.

14. State commissions on child support.—The Governor of each State is required to appoint a State Commission on Child Support. The Commission must include representation from all aspects of the child support system including custodial and non-custodial parents, the IV-D agency, the judiciary, the Governor, the legislature, child welfare and social services agencies, and others.

Each State commission is to examine the functioning of the State child support system with regard to securing support and parental involvement for both AFDC and non-AFDC children, including but not limited to such specific problems as: (1) visitation; (2) establishment of appropriate objective standards for support; (3) enforcement of interstate obligations; and (4) additional Federal and State legislation needed to obtain support for all children.

15. Requirement to include medical support as part of any child support order.—The Secretary of Health and Human Services is required to issue regulations to require State agencies to petition to include medical support as part of any child support order whenever health care coverage is available to the absent parent at a reasonable cost. The regulations must also provide for improved information exchange between the State IV-D agencies and the medicaid agencies with respect to the availability of health insurance coverage.

16. Increased availability of Federal parent locator services to State agencies.—The prior law requirement that the States exhaust all State child support locator resources before they request the assistance of the Federal Parent Locator Service is repealed.

17. Extension of medicaid eligibility when support collection results in termination of AFDC eligibility.—If a family loses AFDC eligibility as the result (wholly or partly) of increased collection of support payments under the IV-D program, the State must continue to provide medicaid benefits for 4 calendar months beginning with the month of ineligibility. (The family must have received AFDC in at least 3 of the 6 months immediately preceding the month of ineligibility.)

18. Guidelines for determining support obligations.—Each State must develop guidelines to be considered in determining support obligations.

19. Availability of social security numbers for purposes of child support enforcement.—The absent parent's social security number may be disclosed to child support agencies both through the Federal Parent Locator Service and by the IRS.

20. Collection of overdue support from Federal tax refunds.—Current law requires the Secretary of the Treasury, upon receiving notice from a State child support agency that an individual owes past due support which has been assigned to the State as a condition of AFDC eligibility, to withhold from any tax refunds due that individual an amount equal to any past due support. The act extends this requirement to provide for withholding of refunds on behalf of non-AFDC families, under specified conditions.

21. Wisconsin child support initiative.—The Secretary of HHS is required to grant waivers to the State of Wisconsin to allow it to implement its proposed child support initiative in all or parts of the State as a replacement for the AFDC and child support programs. The State must meet specified conditions and give specific guarantees with respect to the financial well-being of the children involved.

22. Sense of the Congress that State and local governments should focus on the problems of child custody, child support, and related domestic issues.—The act incorporates the language of S. Con. Res. 84 urging State and local governments to focus on the vital issues of child support, child custody, visitation rights, and other related domestic issues that are within the jurisdictions of such governments.

Cost estimates for the major provisions of Public Law 98-378 appear below:

TABLE 25.—CBO ESTIMATES FOR CHILD SUPPORT ENFORCEMENT AMENDMENTS OF 1984 (PUBLIC LAW 98-378)

	Fiscal year—				
	1984	1985	1986	1987	Total
Alter incentive payments to States			15	15	30
Reduce Federal matching to 68 percent in fiscal year 1988; 66 percent in fiscal year 1990					0
Require application fees; optional late payment fees		−5	−10	−10	−25
Mandate State enforcement techniques		−15	−25	−25	−65
Require IRS tax intercept for non-AFDC families thru fiscal year 1989		25	20	10	155
Authorize funds for interstate projects		7	12	15	34
Provide Medicaid for 4 months for families losing AFDC due to child support collection through fiscal year 1988	5	25	25	30	85
Other provisions		15	20	10	45
Impact of H.R. 4325 on CSE case levels:					
CSE expenditures		10	30	55	95
Offsetting effects on public assistance		−5	−20	−30	−55
Total	5	57	67	70	199

Note: The cost of disregarding the first $50 of child support payments is shown in the AFDC section.

The Tax Reform Act of 1984 (Public Law 98-369) was also enacted during the 98th Congress and included two tax provisions pertaining to alimony and child support.

Under prior law, alimony was deductible by the payor and includible in the income of the payee. The new law revises the rules relating to the definition of alimony. Generally, only cash payments that will terminate on the death of the payee spouse will qualify as alimony. Alimony payments, if in excess of $10,000 per year, generally must be payable for at least 6 years and must not decline by more than $10,000. The prior law requirement that the payment be based on a legal support obligation has been repealed and payors are now required to furnish to the IRS the social security number of the payee spouse. A $50 penalty for failure to do so will be imposed. The provision is effective for divorce or separation agreements or orders executed after 1984.

The new law also provides that the $1,000 dependency exemption for a child of divorced or separated parents generally will be allocated to the custodial parent unless the custodial parent signs a written declaration that he or she will not claim the exemption for the year. Each parent may claim the medical expenses that he or she pays for the child, for purposes of computing the medical expense deduction. The provision is effective for taxable years beginning after 1984.

LEGISLATIVE CHANGES IN THE 97TH CONGRESS

The 97th Congress enacted child support legislation in 1981 and 1982 which had the effect of reducing Federal outlays, as shown below. Estimates for savings were made by the Congressional Budget Office.

Changes included in the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) and the Tax Equity and Fiscal Responsibility Act of 1983 (Public Law 97-248) are:

TABLE 26.—CBO ESTIMATES FOR PUBLIC LAW 97-35 AND PUBLIC LAW 97-248

[In millions of dollars]

Provision	Fiscal year—				
	1982	1983	1984	1985	1986
Public Law 97-35:					
Collection of past-due child and spousal support from Federal tax refunds	−55	−70	−75	−75	−75
Collection of support for certain spouses	−20	−20	−20	−20	−20
Require absent parents to pay fee for services to non-AFDC families	0	0	0	0	0
Child support obligations owed on behalf of AFDC families not discharged in bankruptcy	−15	−18	−23	−29	−36
Require States to intercept unemployment benefits to enforce child support obligations	−17	−17	−17	−17	−17
Total	−107	−125	−135	−141	−148
	Fiscal year—				
	1983	1984	1985	1986	1987
Public Law 97-248:					
Give States the option of imposing a fee for services to non-AFDC families	−12	−16	−11	−13	−14
Require allotments from pay for support owed by members of the uniformed services	−7	−9	−10	−10	−10
Reimbursement of State agency in initial month of ineligibility for AFDC	−3	−4	−4	−5	−5
Reduce Federal incentive payments and Federal matching percentage	−40	−91	−101	−111	−116
Total	−62	−120	−126	−139	−145

Section 9. SSI Program Description

The Supplemental Security Income (SSI) program is a federally administered income assistance program authorized by title XVI of the Social Security Act. Established by the 1972 amendments to the Act (Public Law 92–603) and begun in 1974, SSI provides monthly cash payments in accordance with uniform, nationwide eligibility requirements to needy aged, blind and disabled persons. The SSI program replaced the former Federal grants to the States for old-age assistance, aid to the blind and aid to the permanently disabled. These grants continue in Guam, Puerto Rico and the Virgin Islands. SSI, however, operates in the Northern Mariana Islands.

BASIC ELIGIBILITY

To qualify for SSI payments, a person must satisfy the program criteria for age, blindness or disability. The aged are defined as persons 65 years and older. The blind are individuals with 20/200 vision or less with the use of a correcting lens in the person's better eye, or those with tunnel vision of 20 degrees or less. Disabled individuals are those unable to engage in any substantial gainful activity by reason of a medically determined physical or mental impairment expected to result in death or that has lasted, or can be expected to last, for a continuous period of at least 12 months. Also, a child under age 18 who has an impairment of comparable severity with that of an adult may be considered disabled.

As explained later, disabled SSI recipients who lose eligibility for regular SSI benefits and for Medicaid because their earnings have exceeded the "substantial gainful activity" earnings test, but who continue to be medically disabled, can continue to receive cash assistance and Medicaid under certain conditions.

SSI BENEFIT STANDARDS

Individuals and couples applying for or receiving SSI benefits are determined to be eligible if their countable income does not exceed certain income benefit standards.

Regular Federal SSI benefit standard

The regular Federal SSI benefit standard for an individual for 1988 is $354 a month and $532 for a couple. As is discussed later, most States supplement the regular Federal SSI benefit standard. The result is a combined regular Federal SSI/State supplementation benefit standard against which countable income is compared in determining eligibility and benefit amount. However, many States limit their supplementation to certain categories of individuals based on specific indicators of need—especially special housing needs. In December 1987, 365,702 persons, or 8.3 percent of all SSI recipients, were eligible for benefits only because State supplementation increased the benefit standard.

The regular Federal SSI benefit standards are indexed to the Consumer Price Index (CPI) and by the same percentage as Social Security benefits. This occurs through a reference in the SSI law to the Social Security cost-of-living adjustment (COLA) provision. Prior to the Social Security Amendments of 1983 (Public Law 98-21), the SSI and Social Security cost-of-living increases occurred in benefits paid in July. Public Law 98-21 delayed the Social Security and SSI COLA's from July 1983 to January 1984. However, in lieu of a COLA increase in the SSI benefit standard in July 1983, the regular Federal SSI benefit standard was increased in July 1983 by $20 a month for an individual and $30 a month for a couple. Table 1 shows the regular Federal SSI benefit standard from the beginning of the SSI program until the present time.

Living in the household of another

The SSI law provides that if an SSI applicant or recipient is "living in another person's household and receiving support and maintenance in-kind from such person", the value of such in-kind assistance is presumed to equal one-third of the regular Federal SSI benefit standard. The Federal SSI benefit standard applicable to such individual or couple is two-thirds of the regular Federal SSI benefit standard. As shown in table 1, the Federal SSI benefit standard for those determined to be living in the household of another is $236 for an individual and $354.67 for a couple. These amounts are increased annually since they are two-thirds of the regular Federal SSI benefit standard.

By regulation, the Social Security Administration has established certain criteria for determining whether this benefit standard should be applied. If an individual actually owns or rents the living quarters or contributes their pro rata share to the household's expenses, this lower benefit standard does not apply. In September 1987, 5.7 percent, or 248,000 SSI recipients, had their benefits determined on the basis of this "one-third reduction" benefit standard. Sixty-eight percent of those recipients were receiving benefits on the basis of disability (see table 2).

Of the 27 States that supplement the regular Federal SSI benefit standard, 12 States provide the same amount of supplementation for those whose Federal SSI benefit amount is determined on the basis of the "one-third reduction" Federal standard. Seven States provide a higher State supplementation for such recipients and in eight States the amount of State supplementation is less. In two States, a higher State supplement is provided for the blind and a lower State supplement is provided for the aged.

Medicaid institution/personal needs allowance

When an individual enters a hospital or other medical institution in which a major part of a bill is paid by the Medicaid program, his monthly SSI benefit standard is reduced to $25, beginning with the first full calendar month the individual is in such institution. This Personal Needs Allowance (PNA) is intended to take care of small personal expenses, with the cost of maintenance and medical care being provided through Medicaid. The Federal PNA benefit standard of $25 will increase to $30 a month effective July 1, 1988—the first increase since the SSI program began in 1974. The annual cost-of-living increase for SSI does not apply to the personal needs allowance Federal benefit standard. The 1987 Budget Reconciliation Act does, however, provide that if a physician certifies that a person's stay in such a medical institution is not likely to exceed 3 months and the person needs to continue to maintain a home to return to, that the SSI benefits will not be reduced and he or she will continue on the full SSI benefit standard for up to 3 months.

Approximately 191,000, or 4.4 percent, of SSI recipients received benefits in September 1987 on the basis of this benefit standard. For those individuals whose income from non-SSI sources exceeds the $25 benefit standard (including those who previously, when they were not living in a medical institution, were receiving some SSI because their Social Security benefits are less than the regular SSI benefit standard), Medicaid regulations require States to allow such individuals (and other non-SSI Medicaid eligibles) to retain no less than $25 a month ($30 after July 1, 1988) of their income as a "personal needs allowance" when their income is applied, along with Medicaid reimbursement, to pay for their institutional medical care. Approximately 600,000 additional individuals in nursing homes are affected by this requirement.

Approximately 12 States have exercised their option to supplement this Federal SSI benefit standard. Prior to the 1985 Budget Reconciliation Act, SSI regulations would not allow for Federal administration of the State supplements of these payments. An amendment included in that legislation now requires the Social Security Administration, at the request of a State, to administer such State supplementary payments. As of July 1987, California, Massachusetts, and Maine had opted for Federal administration. Approximately 24 States allow some or all of those individuals affected by the Medicaid personal needs allowance regulations to retain more than $25 a month.

TABLE 1.—FEDERAL SSI BENEFIT STANDARDS

[In dollars]

Period	Eligibility status					
	Single		Couple		Medicaid facilities	Essential person
	Own household	Another household	Own household	Another household		
Jan. 1974–June 1974	140.00	93.34	210.00	140.00	25.00	70.00
July 1974–June 1975	146.00	97.34	219.00	146.00	25.00	73.00
July 1975–June 1976	157.70	105.14	236.60	154.74	25.00	78.90
July 1976–June 1977	167.80	111.87	251.80	167.87	25.00	84.00
July 1977–June 1978	177.80	118.54	266.70	177.80	25.00	89.00
July 1978–June 1979	189.40	126.27	284.10	189.40	25.00	94.80
July 1979–June 1980	208.20	138.80	312.30	208.20	25.00	104.20
July 1980–June 1981	238.00	158.67	357.00	238.00	25.00	119.20
July 1981–June 1982	264.70	176.47	397.00	264.67	25.00	132.60
July 1982–June 1983	284.30	189.54	426.40	284.27	25.00	142.50

TABLE 1.—FEDERAL SSI BENEFIT STANDARDS—Continued

[In dollars]

Period	Eligibility status					
	Single		Couple		Medicaid facilities	Essential person
	Own household	Another household	Own household	Another household		
July 1983–Dec. 1983	304.30	202.88	456.40	304.27	25.00	152.50
Jan. 1984–Dec. 1984	[1] 314.00	209.34	[1] 472.00	314.67	25.00	157.00
Jan. 1985–Dec. 1985	325.00	216.67	488.00	325.34	25.00	163.00
Jan. 1986–Dec. 1986	336.00	224.00	504.00	336.00	25.00	168.00
Jan. 1987–Dec. 1987	340.00	226.67	510.00	340.00	25.00	170.00
Jan. 1988–Dec. 1988	354.00	236.00	532.00	354.67	[2] 25.00	177.00

[1] Cost-of-living adjustments to Federal SSI benefit levels are rounded to the next lower whole dollar beginning with the increase effective January 1984.

[2] Personal Needs Allowance for residents of Medicaid institutions will increase to $30 effective July 1, 1988.

Source: Office of Research and Statistics, Social Security Administration.

Another benefit standard affecting some persons involves Federal payments to an individual who was transferred to SSI from a former State program of aid to the aged, blind or disabled. These payments are increased by $177 monthly to take into account an "essential person" living in the household. An essential person is generally an ineligible spouse or relative whose needs were considered in determining the requirements of an eligible individual under the former State program but who is not eligible for SSI. Some States have categories of State supplementation similar to the "essential persons" category for individuals transferred from the pre-SSI program.

TABLE 2.—NUMBER AND PERCENTAGE DISTRIBUTION OF PERSONS RECEIVING FEDERALLY ADMINISTERED PAYMENTS, BY REASON FOR ELIGIBILITY AND FEDERAL SSI BENEFIT STANDARD/LIVING ARRANGEMENT, SEPTEMBER 1987

Federal benefit standard/living arrangement	Total	Reason for eligibility		
		Aged	Blind	Disabled
Total number	4,351,082	1,455,081	83,301	2,812,700
Total percent	100.0	100.0	100.0	100.0
Regular Federal SSI benefit standard	89.8	90.9	90.1	89.2
Living in the household-of-another Federal SSI benefit standard	5.7	4.9	6.1	6.0
Medicaid institution/personal needs allowance Federal SSI benefit standard	4.4	4.1	3.8	4.7

Source: Office of Research and Statistics, Social Security Administration.

INCOME DISREGARDS

Under the program, $20 of monthly income from virtually any source (such as social security benefits, but *not* need-tested income such as veterans' pensions) is disregarded. In addition, the first $65 of monthly earned income plus one-half of remaining earnings are disregarded. Table 3 shows the maximum income that an individual and couple can have and still remain eligible for Federal SSI benefits under the regular Federal SSI benefit standards—taking into account these income disregards.

SSI law requires that an SSI applicant or recipient apply for all other benefits for which they are eligible. For example, in September 1987, 71 percent of the aged, 37 percent of the disabled, and 39 percent of the blind receiving SSI were also Social Security recipients.

For the blind and disabled only, the cost of an approved plan to achieve self-support is also disregarded. SSI recipients who receive benefits on the basis of blindness may also disregard work related expenses. For the disabled, only impairment related work expenses may be disregarded. Income received in sheltered workshops and work activity centers is considered earned income and qualifies for earned income disregards.

The value of any in-kind assistance is counted as income unless such in-kind assistance is specifically disregarded by statute. Generally, in-kind assistance provided by or under the auspices of a federally assisted program, or by a State or local government (for example, nutrition, food stamps, housing or social services), will not be counted as income. As described earlier, if an SSI applicant or recipient is living in the household of another and receiving in-kind support and maintenance from him or her, the SSI benefit standard for such an individual will be reduced by one-third of the Federal SSI benefit standard. By regulation, the Social Security Administration has also provided that the value of any in-kind support and maintenance received (other than in the case of those receiving in-kind assistance by reason of living in another's household), is presumed to be equal to no more than one-third of the Federal SSI benefit standard plus $20. The individual can rebut this presumption. If it is determined that the actual value is less than the one-third amount, the lower actual value will be counted as unearned income.

In legislation enacted in April 1983, in-kind support and maintenance provided by a private nonprofit organization to aged, blind, or disabled individuals must be disregarded under the SSI program if the State determines that the assistance is provided on the basis of need. Another exclusion from income is certain types of assistance provided to help meet home energy needs. Assistance provided to an aged, blind, or disabled individual for the purpose of meeting home energy costs either in cash or in kind and which is furnished by a home heating oil or gas supplier or by a utility company is to be disregarded. Assistance for home energy costs provided in-kind by a private nonprofit organization is also excluded.

As countable income (total income minus disregarded income) increases, a recipient's SSI payment level decreases. Eligibility for SSI ends when countable income equals the Federal benefit standard plus the amount of applicable State supplementation.

A provision in the 1984 Deficit Reduction Act established a limit on the rate of recovery from SSI recipients who have been overpaid. In the case of overpayments, SSI law limits the amount of adjustment or recovery in any month to the lesser of: (1) the amount of the benefit for that month; or (2) an amount equal to 10 percent of the countable income (including the SSI payment) of the individual (or couple) for that month. This limitation does not apply if there is fraud in connection with the overpayment. The recipient may request a different rate at which benefits or income may be withheld or recovered.

TABLE 3.—MAXIMUM INCOME FOR ELIGIBILITY FOR FEDERAL SSI BENEFITS, 1988

	Receiving only Social Security		Receiving only wage income	
	Monthly	Annually	Monthly	Annually
Individual	$374	$4,488	$793	$9,516
Couple	552	6,624	1,149	13,788

Source: Office of Research and Statistics, Social Security Administration.

RESOURCES

SSI eligibility is restricted to qualified persons who have countable assets of less than $1,900, or less than $2,850 in the case of married couples. The Deficit Reduction Act of 1984 (P.L. 98-369) increased the countable assets limit by $100 a year for an individual and $150 a year for a couple, beginning in calendar year 1985 and each year through calendar year 1989. Prior to January 1, 1985, the assets limit for an individual was $1,500 and $2,250 for a couple. The limit will be $2,000 for an individual and $3,000 for a couple in 1989 and thereafter.

In determining assets, a number of items are not included, such as the individual's home; and, within reasonable limits set by the Secretary of Health and Human Services: household goods, personal effects, an automobile, and a burial space for the individual, spouse, and members of the immediate family. Regulations place a limit of $2,000 in equity value on excluded household goods and personal effects and exclude the first $4,500 in current market wholesale value of an auto (100 percent of the auto's value if it is used for medical treatment or employment or has been modified for use by a handicapped person or is necessary to perform essential daily activities in unusual climate or terrain). Assets, tools and other property essential to self-support of the blind or the disabled are also excluded. SSI and title II retroactive benefit payments may not be considered as a resource for a period of 9 months after the month in which the retroactive benefit is received.

The cash value of life insurance policies with face values of $1,500 or less are not counted toward the $1,900 or $2,850 countable resources limit. The entire cash value of life insurance policies with face values greater than $1,500 is counted toward the countable resources limit. As an alternative to the life insurance exclusion, an SSI recipient may have excluded from countable resources up to $1,500 in separately identifiable funds set aside for burial expenses. However, term insurance or irrevocable burial trusts will also serve to reduce the $1,500 burial fund limit. Interest earned on burial accounts is not counted as either income or as a resource for SSI purposes.

Current law provides that an individual (or eligible spouse) who gives away or sells any nonexcludable resource for less than fair market value for the purpose of establishing SSI or Medicaid eligibility will have any uncompensated value of that resource (the difference between fair market value at the time of the transfer and the amount received for the resource) counted toward the resources limit of $1,900 for an eligible individual and $2,850 for a couple for a period of 24 months from the date of transfer. The 1987 Budget Reconciliation Act provides authority for the Social Security Administration to not apply this penalty if necessary to avoid undue hardship.

The Deficit Reduction Act of 1984 (P.L. 98-369) requires the Internal Revenue Service to furnish the Social Security Administration with certain nonwage information about SSI recipients. The IRS information consists primarily of reports of interest payments submitted to IRS by financial institutions but also includes income from dividends, unemployment compensation, etc. The purpose of the provision was to assist in alerting the Social Security Administration of the potential ownership by SSI recipients of bank accounts in excess of the SSI countable resources limit. In fiscal year 1987, computer matches between IRS tax files and SSI records resulted in 239,000 such matches. Only cases involving IRS reports of interest income of $51 or more were examined. The resulting savings to the SSI program were $64 million. As a result of the Social Security Administration's evaluation of these cases, the tolerance level was lowered to $41 beginning with fiscal year 1988. In October 1987, approximately 398,000 matches were identified using this lower tolerance level and were sent to Social Security offices for verification of the information. The current year effort is expected to result in savings of $71 million.

Prior to the 1984 Deficit Reduction Act, if in any month a recipient's assets exceeded the asset limit, the individual was ineligible for benefits in that month and the entire amount of the benefit paid for that month was considered an overpayment subject to recovery. Now SSI law provides that in cases where there is an overpayment based on an excess of assets of $50 or less, the recipient is deemed to be without fault for purposes of waiving the overpayment and the overpayment is not recovered unless the Secretary finds that the failure to report the excess was knowing and willful on the part of the recipient.

An individual may receive SSI benefits for a limited time even though he has property that, if counted, would make him ineligible. These benefits are conditioned upon the disposal of the property, and are subject to recovery as overpayments when the property is sold. The 1987 Budget Reconciliation Act provides, in addition, for the exclusion of real property, for so long as it cannot be sold, because it is jointly owned; legal impediments; or reasonable efforts to sell it have been unsuccessful.

DEEMING OF INCOME AND RESOURCES

The income of an ineligible spouse who lives with an adult SSI applicant or recipient is considered in determining the eligibility and amount of payment to the individual. The income of the parents of a disabled or blind child under the age of 18 is also considered in determining the eligibility and payment for the child. The law also provides that deeming of income and resources shall occur "except to the extent determined by the Secretary to be inequitable under the circumstances".

By regulation, the Secretary of HHS has provided that in determining the amount of the income of the ineligible spouse or parent to be deemed to the SSI applicant or recipient, the needs of the spouse or parent and other children in the household are taken into account. In addition, the SSI earned and unearned income disregards are applied in determining the amount of income to be deemed to the SSI applicant or recipient. If the combined countable income of an eligible individual and an ineligible spouse does not exceed the SSI benefit standard for an eligible couple in that State (including any State supplementary payment), the SSI applicant or recipient would be eligible to receive an SSI benefit.

For example, in a State with no State supplementation the deeming procedure would work as follows in the case of an ineligible spouse earning $500 per month living with an eligible individual with $180 of Social Security benefits:

Unearned income of eligible individual	$180.00
Less $20 exclusion	−20.00
Countable unearned income	160.00
Earned income of ineligible individual	500.00
Less $65 earned income disregard	−65.00
Less one-half of remaining earnings ($435)	−217.50
Countable earned income	217.50
Plus countable unearned income	160.00
Couple's total countable income	377.50
SSI payment standard for couples	532.00
Less countable income	−377.50
Benefit payable to eligible individual	154.50

Thus the benefit for the eligible individual will be $154.50. Without deeming, the individual would have received $194 [$354−($180 less $20 exclusion)]. The $20 exclusion can only be used once and is first applied to unearned income, which in this example is the $180 of Social Security income.

An individual's resources are deemed to include those of his ineligible spouse (or in the case of a child under the age of 18, those of his parents) with whom he lives. Under the Secretary's regulations, in determining the amount of the spouse's or parents' resources that can be deemed all applicable exclusions are applied. In the case of a child, only the value of the parents' resources that exceeds the applicable limits ($1,900 for a single parent, and $2,850 for two parents) is deemed to the child.

There are 41,200 spouse-to-spouse and 22,500 parent-to-child cases currently in which deeming reduces the benefit. This does not take into account the number of individuals who are not eligible because of the deeming provision.

In determining the eligibility of aliens applying for SSI, the income and resources of their sponsors are considered. After allowances for the needs of the sponsors and his family, the remainder is deemed available for the support of the alien applicant for a 3-year period after entry into the United States. This provision does not apply to those who become blind or disabled after entry, to refugees, and to persons granted political asylum.

RESTRICTIONS ON SSI ELIGIBILITY OF RESIDENTS OF PUBLIC INSTITUTIONS

An individual who is a resident or an inmate of a public institution is ineligible for SSI unless the institution is a facility approved for Medicaid payments, is receiving such payments on behalf of the person, and these payments represent more than 50 percent of the cost of services provided by the facility to the person. However, SSI payments may be made to persons in publicly operated community residences serving no more than 16 persons. In addition, temporary residents of public emergency shelters can receive SSI payments for up to 6 months in any 9-month period.

The 1987 Budget Reconciliation Act provided for a further exception for those who are in public institutions for psychiatric care. As in the case for temporary care in a nursing home or other medical institution, if a physician certifies that the stay in the psychiatric hospital is not expected to exceed 3 months, the individual can maintain their eligibility for SSI benefits for up to 3 months in order to maintain a living arrangement in the community.

STATE SUPPLEMENTATION

State supplementary payments are required by law to maintain income levels of former public assistance recipients transferred to the Federal SSI program. In January 1986, approximately 7,976 recipients were receiving payments based in part or solely because of this provision. States have the option to choose to supplement the Federal SSI benefit standard for both former public assistance recipients and other SSI recipients. At the present time, all but eight States and jurisdictions provide some form of optional State supplementation. Those are: Arkansas, Georgia, Kansas, Mississippi, Northern Mariana Islands, Tennessee, Texas, and West Virginia. States (or local jurisdictions) may elect to administer their supplementary payments themselves or may contract with the Social Security Administration for Federal administration. Seventeen States and the District of Columbia have contracted with the Social Security Administration to administer the State optional supplementation program. Since the SSI program began in 1974, six States have shifted from Federal to State administration of their optional State supplementation program.

Approximately 44 percent of the SSI recipients receive a State supplement. For those SSI recipients, other than those receiving a State supplement because they are living in some type of group living arrangement, the amount of State supplement ranges from $2 a month to $393 a month for an individual. At present, 27 States and the District of Columbia supplement the Federal standard for individuals living independently.

Table 22 shows the number of persons receiving State administered payments and federally administered SSI payments by State for December, 1987.

Table 4 for individuals living independently and table 5 for couples illustrate the maximum potential payment from Federal SSI, State supplements and food stamps for individuals, with no income, by State. These tables assume that the elderly individual or couple receive an excess shelter deduction of $164 and an excess medical cost deduction of $8 in the food stamp program. Approximately 67 percent of the elderly in the food stamp program take a shelter deduction, and it is estimated that approximately 21 percent of the elderly are allowed a deduction of $164 or more. However, since only 12 percent of the elderly claim a medical cost deduction, the average of medical cost deductions over all elderly recipients (both those who claim and those who do not) was used in the table, instead of the average $61 deduction taken by the small minority who claim it. If the higher medical deduction level were used, food stamp benefits shown in the table would be increased by about $15. For those individuals or couples with no shelter deduction, the monthly food stamp and combined benefit amount would be reduced by $50. There is no ceiling on the excess shelter deduction for aged or disabled persons.

TABLE 4.—MAXIMUM POTENTIAL SSI AND FOOD STAMP BENEFITS FOR AGED INDIVIDUALS LIVING INDEPENDENTLY, JANUARY 1988 [1]

State	Maximum SSI benefit	Food stamp benefit [2]	Combined benefits	
			Monthly	Annual
Alabama	$354	$63	$417	$5,004
Alaska	659	55	714	8,568
Arizona	354	63	417	5,004
Arkansas	354	63	417	5,004
California	575	[3] 0	575	6,900
Colorado	412	45	457	5,484
Connecticut*	[4] 747	0	747	8,964
Delaware	354	63	417	5,004
District of Columbia	369	58	427	5,124
Florida	354	63	417	5,004
Georgia	354	63	417	5,004
Hawaii	359	133	492	5,904
Idaho	[5] 427	47	474	5,688
Illinois*	[6] NA	NA	NA	NA
Indiana	354	63	417	5,004
Iowa	354	63	417	5,004
Kansas	354	63	417	5,004
Kentucky	354	63	417	5,004
Louisiana	354	63	417	5,004
Maine	364	60	424	5,088
Maryland	354	63	417	5,004
Massachusetts	483	24	507	6,084
Michigan	384	54	438	5,256
Minnesota	[7] 389	52	441	5,292
Mississippi	354	63	417	5,004
Missouri	354	63	417	5,004
Montana	354	63	417	5,004
Nebraska	397	50	447	5,364
Nevada	390	52	442	5,304
New Hampshire	[8] 381	58	439	5,268
New Jersey	385	53	438	5,256
New Mexico	354	63	417	5,004
New York	426	41	467	5,604
North Carolina	354	63	417	5,004
North Dakota	354	63	417	5,004
Ohio	354	63	417	5,004
Oklahoma	418	43	461	5,532
Oregon	356	62	418	5,016
Pennsylvania	386	53	439	5,268

TABLE 4.—MAXIMUM POTENTIAL SSI AND FOOD STAMP BENEFITS FOR AGED INDIVIDUALS LIVING INDEPENDENTLY, JANUARY 1988 [1]—Continued

State	Maximum SSI benefit	Food stamp benefit [2]	Combined benefits	
			Monthly	Annual
Rhode Island	$413	$45	$458	$5,496
South Carolina	354	63	417	5,004
South Dakota	369	58	427	5,124
Tennessee	354	63	417	5,004
Texas	354	63	417	5,004
Utah	363	60	423	5,076
Vermont	[9] 412	45	457	5,484
Virginia	354	63	417	5,004
Washington	[10] 382	54	436	5,232
West Virginia	354	63	417	5,004
Wisconsin	457	[3] 0	457	5,484
Wyoming	374	57	431	5,172

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* Data obtained from State by CRS.

[1] In most States these maximums apply also to blind or disabled SSI recipients who are living in their own households; but some States provide different benefit schedules for each category.

[2] For one-person households, maximum food stamp benefits from Oct. 1987 through Sept. 1988 are $87 in the 48 contiguous States and the District of Columbia, $113 in Alaska (urban areas, benefit levels in rural Alaska are increased by about 50 percent to account for higher food prices in such areas), and $133 in Hawaii.

For the 48 contiguous States and D.C., the calculation of benefits assumes: (1) a "standard" deduction of $102 per month, (2) an excess shelter deduction of $164 per month (the maximum allowable for nonelderly, nondisabled households); and (3) an excess medical expense deduction of $8 monthly (estimated from 1985 medical expense information). If smaller excess shelter costs were assumed, food stamp benefits would be smaller. For Alaska and Hawaii, higher deduction levels were used, as provided by law ($460 and $378, respectively, for combined standard and excess shelter allowance).

[3] SSI recipients in California and Wisconsin are ineligible for food stamps. These States provide increased cash aid in lieu of stamps.

[4] Individual budget process. Maximum SSI benefit level is based on highest rental allowance of $400 per month.

[5] State disregards $20 of SSI payment in determining the State supplementary payment.

[6] State decides benefits on case-by-case basis. The average payment was $57 per month in November 1987.

[7] Payment level for Hennepin County. State has 10 geographic payment levels.

[8] State disregards $13 of an individual's income in determining the supplementary payment. The State supplementary payment amount is rounded to next higher dollar.

[9] State has two geographic payment levels—highest are shown in table.

[10] Sum paid in King, Pierce, Kitsap, Snohomish, and Thurston Counties.

Source: Table prepared by the Congressional Research Service (CRS) on the basis of data from the Social Security Administration (except for Connecticut and Illinois).

TABLE 5.—MAXIMUM POTENTIAL SSI AND FOOD STAMP BENEFITS FOR AGED COUPLES LIVING INDEPENDENTLY, JANUARY 1988 [1]

State	Maximum SSI benefit	Food stamp benefit [2]	Combined benefits	
			Monthly	Annual
Alabama	$532	$81	$613	$7,356
Alaska	976	54	1,030	12,360
Arizona	532	81	613	7,356
Arkansas	532	81	613	7,356
California	1,066	[3] 0	1,066	12,792
Colorado	648	46	694	8,328
Connecticut*	[4] 1,134	0	1,134	13,608
Delaware	532	81	613	7,356
District of Columbia	562	72	634	7,608
Florida	532	81	613	7,356
Georgia	532	81	613	7,356
Hawaii	541	197	738	8,856
Idaho	[5] 576	74	650	7,800
Illinois*	[6] NA	NA	NA	NA
Indiana	532	81	613	7,356
Iowa	532	81	613	7,356
Kansas	532	81	613	7,356
Kentucky	532	81	613	7,356
Louisiana	532	81	613	7,356
Maine	547	77	624	7,488
Maryland	532	81	613	7,356
Massachusetts	734	21	755	9,060
Michigan	577	68	645	7,740
Minnesota	[7] 598	61	659	7,908
Mississippi	532	81	613	7,356
Missouri	532	81	613	7,356
Montana	532	81	613	7,356
Nebraska	598	61	659	7,908
Nevada	606	59	665	7,980
New Hampshire	[8] 553	81	634	7,608
New Jersey	557	74	631	7,572
New Mexico	532	81	613	7,356
New York	625	53	678	8,136
North Carolina	532	81	613	7,356
North Dakota	532	81	613	7,356
Ohio	532	81	613	7,356
Oklahoma	660	43	703	8,436
Oregon	532	81	613	7,356
Pennsylvania	581	66	647	7,764

TABLE 5.—MAXIMUM POTENTIAL SSI AND FOOD STAMP BENEFITS FOR AGED COUPLES LIVING INDEPENDENTLY, JANUARY 1988 [1]—Continued

State	Maximum SSI benefit	Food stamp benefit [2]	Combined benefits	
			Monthly	Annual
Rhode Island	$643	$48	$691	$8,292
South Carolina	532	81	613	7,356
South Dakota	547	77	624	7,488
Tennessee	532	81	613	7,356
Texas	532	81	613	7,356
Utah	550	76	626	7,512
Vermont	[9] 638	49	687	8,244
Virginia	532	81	613	7,356
Washington	[10] 554	75	629	7,548
West Virginia	532	81	613	7,356
Wisconsin	698	[3] 0	698	8,376
Wyoming	572	69	641	7,692

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* Data obtained from State by CRS.

[1] In most States these maximums apply also to blind or disabled SSI recipients who are living in their own households; but some States provide different benefit schedules for each category.

[2] For two-person households, maximum food stamp benefits from Oct. 1987 through Sept. 1988 are $159 in the 48 contiguous States and the District of Columbia, $207 in Alaska (urban areas, benefit levels for rural Alaska are about 50 percent higher to account for high food prices in such areas), and $244 in Hawaii. For the 48 contiguous States and D.C., the calculation of benefits assumes: (1) a "standard" deduction of $102 per month, (2) an excess shelter deduction of $164 per month (the maximum allowable for nonelderly, nondisabled households); and (3) an excess medical expense deduction of $8 monthly (estimated from 1985 medical expense information). If smaller excess shelter costs were assumed, food stamp benefits would be smaller. For Alaska and Hawaii, higher deduction levels were used, as provided by law ($460 and $378, respectively, for combined standard and excess shelter allowance).

[3] SSI recipients in California and Wisconsin are ineligible for food stamps. These States provide increased cash aid in lieu of stamps.

[4] Individual budget process. Maximum benefit level is based on highest housing allowance of $400 per month.

[5] State disregards $20 of SSI income in determining the State supplementary payment amounts.

[6] State decides benefits on case-by-case basis. The average payment was $57 per month in November 1987.

[7] Payment level for Hennepin County. State has 10 geographical payment levels.

[8] State disregards $20 of a couple's SSI income in determining supplementary payment amounts. State supplementary payment amounts are rounded to next higher dollar.

[9] State has two geographic payment levels—highest levels are shown in table.

[10] Sum paid in King, Pierce, Kitsap, Snohomish, and Thurston Counties.

Source: Table prepared by the Congressional Research Service (CRS) on the basis of data from the Social Security Administration (except for Connecticut and Illinois).

STATE SSI SUPPLEMENT LEVELS OVER TIME

Throughout the entire period from July 1975 to January 1988, 23 States have continuously provided supplemental SSI payments to aged individuals living independently, and 21 States continuously supplemented SSI payments to aged couples living independently.

During the period of July 1975 to January 1988, Alaska, California, Colorado, Michigan, New Hampshire, and Oklahoma were the only States which increased supplements faster than inflation for aged individuals living independently (see table 23).

The District of Columbia, South Dakota, Utah, and Wyoming all began supplementing SSI payments to individuals between 1975 and 1980.

Among the States which have supplemented SSI payments for aged couples living independently, only Alaska, Michigan, and Oklahoma have kept their supplemental increases equivalent to or higher than inflation.

STATE SUPPLEMENTATION FOR SPECIAL HOUSING NEEDS

A significant number of the aged, disabled and blind population receiving SSI cannot live alone because of mental or physical limitations and have a need for housing which involves services beyond room and board. These services often include supervision for daily living and protective services for the mentally retarded, chronically mentally ill, or the frail or confused elderly. Such nonmedical supervised and/or group living arrangements generally cost more than the Federal SSI benefit needs standard of $354 a month and often more than the combined Federal and SSI State supplementation for those classified as living independently.

All but 8 of the 52 States and jurisdictions have Federal or State administered State supplementation which is specifically directed at covering the additional cost of providing housing in a protective, supervised, or group living arrangement.

These living arrangements are identified by a variety of terms including: adult foster care homes; domiciliary care homes; congregate care; group home for the mentally retarded and a variety of other terms. The amount of supplementation by the State also varies a great deal. For example, in the State of Maryland under a State-administered supplementation program, a "special services" group living facility for the chronically mentally ill has a State supplementation of $635 a month in addition to the Federal benefit level of $340. In addition, the State disregards $72.50 per month of any income, including Federal SSI, in determining the amount of State supplementation. Therefore, the total Federal and State SSI payment in a month is $975. In other States the State supplementation is less than $50 a month for those who need little supervision and care. However, in some States, the cost of supervised group living care is also partially met by direct State funding of the staff. In a number of States, the State makes payments for nonmedical group care directly to private residential facilities based on a rate negotiated by the State with each facility. In such cases, there is often a "personal needs allowance" payment made directly to or on behalf of the residents of the facility.

SSI OUTREACH AND SPECIAL REHABILITATION SERVICES

The 1983 Social Security Amendments (P.L. 98-21) mandated the Social Security Administration (SSA) to conduct two separate outreach activities aimed at the aged population. The first was a one-time mailing of alerts to those aged individuals and couples whose Social Security benefits were less than the supplemental security income (SSI) eligibility levels. Between February and July 1984 over 7.6 million notices were mailed as part of this one-time alert. SSA used a mail survey questionnaire to evaluate the effects of this alert process. As a result of the one-time outreach effort, there were approximately 160,000 field office contacts. These contacts resulted in 79,000 applications for SSI payments and 58,000 awards, with an average monthly SSI payment of $60 to supplement these recipients' social security benefits. Most of the people who did not contact SSA after receiving the alert reported that they felt that they were ineligible because of too many resources or too much income.

The second outreach activity is an ongoing effort to notify two groups of Social Security beneficiaries: those about to reach age 65; and disabled individuals who have been receiving Social Security benefits for 21 consecutive months and will soon be eligible for Medicare. Beginning in July 1983, and continuing each month, approximately 110,000 aged and disabled social security beneficiaries receive an SSI alert which accompanies the Medicare enrollment notice. Eighty percent of the alerts go to retired beneficiaries, with the remainder sent to disability beneficiaries. The trend in SSI monthly aged awards showed a marked change when this mailing began. SSA estimates that about 2,000 additional aged awards per month have resulted from the ongoing alerts since July 1983.

As a result of these two outreach efforts, the decline in the aged SSI population was temporarily reversed, resulting in a high of 2,083,633 aged recipients in September 1984. Since that date, the aged SSI population has begun to decrease somewhat, although at a slower rate than that experienced before the outreach.

Under the SSI law, certain disabled and blind individuals are referred to the State vocational rehabilitation agency and SSI program funds are available to reimburse States for the cost of such services if the individual, as a result of such services, was able to earn at least $300 a month for at least 9 months.

SSI AND THE HOMELESS

Evidence that approximately 30-40 percent of residents of emergency shelters for the homeless are the chronically mentally ill, including significant numbers of former residents of mental institutions, has led to the enactment of specific legislation and the development of outreach programs and administrative initiatives to better meet the needs of the homeless who may be eligible for SSI.

These initiatives are designed to address special problems related to the characteristics of the homeless: they are often difficult to locate and contact; they have limited ability to find information needed to make application; and they are often incapable or reluctant to follow through with the claim process. While many of the chronically mentally ill live with family or have other ongoing contact with those who can assist them with daily living activities, those mentally ill who are homeless are more likely to have very limited contact with family or others who could assist them in obtaining housing or applying for benefits.

As stated earlier, specific legislative changes were made in 1983 to respond to the needs of the homeless. In-kind support or maintenance provided by a private nonprofit organization is not counted as income under the SSI program if the State determines that the assistance is provided on the basis of need. While residents of most public institutions except small group homes are not eligible for SSI, temporary residents of public emergency shelters can receive SSI benefits for up to 6 months in any 9-month period.

The Social Security Administration also has statutory authority to provide emergency advance payments to individuals applying for SSI who are presumptively eligible for SSI in amounts up to the full SSI monthly benefit standard.

Administrative initiatives by the Social Security Administration to provide assistance to the homeless include:

Outreach.—District office staff of the Social Security Administration have established "contact stations" in shelters in a number of cities. For example, the New York City outreach project has Social Security staff outstationed in seven shelters. Such projects include the use of multiagency outreach teams which include: social services case workers; a consultative medical examiner who is qualified to provide consultative examinations for the Disability Determination Service of the State; a disability examiner, from the Disability Determination Service; and a claims representative from an office of the Social Security Administration. By November 1987, 1,886 applications and related contacts were made under this arrangement and the allowance rate has been 70 percent for the SSI and Social Security cases involved.

"Immediate payments".—Beginning in October 1985, local social security offices were given the authority to make "immediate payments" for certain Social Security and SSI cases when it is found that any delay in payment would result in deprivation of food and/or shelter or endangerment of health. "Immediate" usually means while the beneficiary waits or the next day at the latest. The payments are made using preprinted checks limited to a maximum per beneficiary of $200 or the amount due, whichever is less, in a 30-day period. The person's entitlement to benefits must be verified by the local office. During fiscal year 1987, 6,430 immediate payments were issued under this procedure. The total amount of these payments equaled $1,126,564 for an average of $175 per payment.

Prerelease agreements between public mental institutions and local offices of the Social Security Administration have been a procedure available since the beginning of the SSI program. One of the purposes of these, usually informal, agreements is to identify those disabled individuals who upon release from an institution will be in need of immediate assistance if homelessness is to be prevented. Residents of large public institutions including State mental hospitals generally are not eligible for SSI. Therefore as part of the planning for the release of the patient, there is a determination of their meeting the disability criteria for SSI prior to leaving the institution. In addition, there is a determination that the individual will meet the other SSI eligibility criteria based on a projection of the individual's situation upon leaving the institution. When the decision is favorable, upon release from the institution an SSI payment can be made immediately.

From a recently completed evaluation by the Social Security Administration, it was found that 75 percent of the public mental hospitals and 63 percent of public institutions for the physically handicapped have entered into prerelease agreements with field offices of the Social Security Administration. The percentage for facilities for the mentally retarded or for the treatment of substance abuse was significantly lower. Also, SSA found that in general, prerelease agreements were underutilized. SSA has indicated that they are revising and streamlining the instructions on the use of prerelease agreements.

The 1987 Budget Reconciliation Act authorizes demonstration projects for States to establish projects to demonstrate special procedures and services to ensure that homeless individuals are provided SSI and other benefits to which they are entitled and to receive assistance in using such benefits to obtain permanent housing, food and health care. These projects would include the funding of multiagency SSI outreach teams of the type in operation in New York City.

COMPARISON OF SSI PAYMENT LEVELS TO POVERTY THRESHOLDS

Table 6 compares the Federal SSI benefit for a single individual to the poverty threshold (census). Both the poverty threshold and the benefit level are indexed to the Consumer Price Index. (The percentage increase for the poverty threshold and the SSI benefit increase varies slightly because of a difference in the method of calculation.) As a result of Public Law 98-21, the SSI benefit levels were increased by $20 per month for individuals and $30 per month for couples in July 1983. They were further increased by 3.5 percent in January 1984. This explains why SSI benefits, in relation to the poverty level, increased to approximately 75 percent in 1984 and 1985 compared to 71 percent in the 1975 to 1982 period.

For individuals receiving unearned income such as Social Security, the amount of benefits is $240 per year more than the SSI benefit. Because the $240 amount is not indexed, the percent of poverty is slightly lower in 1987 compared to 1975 despite the SSI benefit increases.

Table 7 presents the same information for a couple. The SSI benefit for a couple is approximately 90 percent of the poverty threshold.

TABLE 6.—COMPARISON OF COMBINED BENEFITS TO POVERTY THRESHOLDS FOR ELIGIBLE INDIVIDUALS RECEIVING SSI; SSI AND SOCIAL SECURITY; AND SSI, SOCIAL SECURITY AND FOOD STAMPS FOR SELECTED YEARS: 1975 TO 1988

	Calendar year					
	1975	1980	1982	1984	1986	1988
Poverty threshold	2,572	3,941	4,630	4,980	5,255	[1] 5,649
Federal SSI benefits:						
Dollars per year	1,822	2,677	3,294	3,768	4,032	4,248
Percent of poverty	70.8	67.9	71.1	75.7	76.7	75.2
Federal SSI and social security:						
Dollars per year	2,062	2,917	3,534	4,008	4,272	4,488
Percent of poverty	80.2	74.0	76.3	80.5	81.3	79.4
Federal SSI, social security, and food stamps: [2]						
Dollars per year	2,350	3,345	3,906	4,294	4,488	4,848
Percent of poverty	91.4	84.9	84.4	86.2	85.4	85.8

[1] Projected on basis of CBO projected increases in the consumer price index.

[2] In computing the food stamp benefit for 1975, average deductions among all elderly households are assumed. For later years, the applicable standard deduction plus average shelter and medical deductions among all elderly households is assumed.

Source: Congressional Research Service.

TABLE 7.—COMPARISON OF COMBINED BENEFITS TO POVERTY THRESHOLDS FOR ELIGIBLE COUPLES RECEIVING SSI; SSI AND SOCIAL SECURITY; AND SSI, SOCIAL SECURITY AND FOOD STAMPS FOR SELECTED YEARS: 1975 TO 1988

	Calendar year					
	1975	1980	1982	1984	1986	1988
Poverty threshold	3,232	4,954	5,840	6,280	6,630	[1] 7,126
Federal SSI benefits:						
Dollars per year	2,734	4,016	4,940	5,664	6,048	6,384
Percent of poverty	84.6	81.1	84.6	90.2	91.2	89.6
Federal SSI and social security:						
Dollars per year	2,974	4,256	5,180	5,904	6,288	6,624
Percent of poverty	92.0	85.9	88.7	94.0	94.8	93.0
Federal SSI, social security, and food stamps: [2]						
Dollars per year	3,430	4,906	5,792	6,393	6,696	7,200
Percent of poverty	106.1	99.0	99.2	101.8	101.0	101.0

[1] Projected on basis of CBO projected increases in the consumer price index.

[2] In computing the food stamp benefit for 1975, average deductions among all elderly households are assumed. For later years, the applicable standard deduction plus average shelter and medical deductions among all elderly households is assumed.

Source: Congressional Research Service.

SSI Program Costs

Table 8 shows the program costs for the SSI program in fiscal years 1986 and 1987 and estimated costs for fiscal years 1988 and 1989. In fiscal year 1987, approximately $9.9 billion of federally financed payments were made to the aged, blind, and disabled. The Federal Government's cost of administering the program was approximately $1 billion. Federal SSI benefits and the cost of administering the program are financed from general funds from the Treasury. The Social Security Administration also administers the payment of approximately $2.5 billion of State financed State supplementary payments. An additional $352 million was paid out in State administered State supplementation payments.

In fiscal year 1987, of the $9.9 billion of Federal SSI benefits, approximately $7.5 billion, or 76 percent, went to those who were eligible on the basis of disability; $2.2 billion, or 22 percent, to the aged; and $200 million, or 2 percent, to the blind.

In addition to the fact that a higher percent of the total SSI population were eligible on the basis of disability rather than age, the higher percent of Federal SSI payments for the disabled is also due to the fact that only 37 percent of the disabled have other income in the form of Social Security benefits compared to 71 percent of the aged.

Table 9 shows the total expenditures for the SSI program in each State, including not only the federally administered Federal and State supplementation payments but also the State administered State supplementation payments.

TABLE 8.—SSI FEDERAL PROGRAM COST BY ACTIVITIES, FISCAL YEARS 1986–1989

[In millions of dollars]

Program by activities	1986	1987	1988 (estimate)	1989 (estimate)
Direct program:				
Federal benefit payments [1]	9,315	9,900	11,397	11,368
Comparable 12 months of payments	(9,315)	(9,900)	(10,500)	(11,368)
Beneficiary services [2]	8	10	13	14
Payments to the trust funds for administrative costs [3]	1,022	976	1,180	1,090
Demonstration	([4])	([4])	1	2
Federal fiscal liability	([4])	23	45	
Total Federal direct program	10,345	10,909	12,636	12,474

[1] 1986, 1987 and 1989 reflect 12 months of payments. 1988 reflects 13 months of payments including the check for October 1, 1988.

[2] Includes rehabilitation services provided to blind and disabled individuals, and monitoring of treatment of drug addicts and alcoholics.

[3] Includes cost of administering Federal SSI payments and Federally administered State supplementation. These are not available separately.

[4] Less than $500,000.

Source: Office of Research and Statistics, and Office of Financial Resources, Social Security Administration.

TABLE 9.—SUPPLEMENTAL SECURITY INCOME: TOTAL PAYMENTS, FEDERAL SSI PAYMENTS, AND FEDERALLY ADMINISTERED AND STATE ADMINISTERED STATE SUPPLEMENTARY PAYMENTS, FISCAL YEAR 1987

[In thousands]

State	Total	Federal SSI	State supplementation	
			Federally administered	State administered
Total	$12,754,002	$9,918,486	[1] $2,483,748	[2] $351,768
Alabama	302,840	291,234		11,606
Alaska	22,805	9,835		12,970
Arizona	100,071	97,026		3,045
Arkansas	152,899	152,867	32	
California	3,084,062	1,354,757	1,729,305	
Colorado	114,455	79,039		35,416
Connecticut	122,688	76,111		46,577
Delaware	19,094	18,391	703	
District of Columbia	48,819	44,554	4,265	
Florida	511,835	500,521	([3])	11,314
Georgia	348,646	348,627	19	
Hawaii	35,401	31,508	3,893	
Idaho	25,453	21,248		4,205
Illinois	479,112	422,256		56,856
Indiana	133,167	130,501		2,666
Iowa	65,208	63,110	2,098	
Kansas	49,917	49,883	34	
Kentucky	265,734	255,625		10,109
Louisiana	310,450	310,403	47	
Maine	48,315	40,861	7,454	
Maryland	152,112	146,607	61	5,444
Massachusetts	324,558	211,997	112,561	
Michigan	379,631	310,852	68,779	
Minnesota	101,803	78,953		22,850
Mississippi	254,332	254,297	35	
Missouri	195,339	190,929		4,410
Montana	20,708	19,864	844	
Nebraska	37,449	31,992		5,457
Nevada	22,045	19,451	2,594	
New Hampshire	22,465	15,964		6,501
New Jersey	284,804	234,808	49,996	
New Mexico	67,935	67,655		280
New York	1,240,694	935,016	305,678	
North Carolina	366,979	319,016		47,963
North Dakota	15,928	14,522		1,406

TABLE 9.—SUPPLEMENTAL SECURITY INCOME: TOTAL PAYMENTS, FEDERAL SSI PAYMENTS, AND FEDERALLY ADMINISTERED AND STATE ADMINISTERED STATE SUPPLEMENTARY PAYMENTS, FISCAL YEAR 1987—Continued

[In thousands]

State	Total	Federal SSI	State supplementation	
			Federally administered	State administered
Ohio	368,398	368,361	37	
Oklahoma	162,895	130,001		32,894
Oregon	79,845	69,503		10,342
Pennsylvania	497,475	424,973	72,502	
Rhode Island	42,970	33,122	9,848	
South Carolina	201,057	196,130		4,927
South Dakota	19,873	19,237	25	611
Tennessee	305,411	305,405	6	
Texas	581,922	581,922		
Utah	25,106	24,251		855
Vermont	26,171	18,487	7,684	
Virginia	214,628	201,782		12,846
Washington	152,597	133,173	19,424	
West Virginia	116,180	116,180		
Wisconsin	224,258	137,895	86,363	
Wyoming	6,120	5,902		218
Other areas:				
Northern Mariana Islands	1,882	1,882		

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[1] Payments reduced by $539,000 to reflect returned checks and overpayment refunds not distributed by State.

[2] Excludes data for Iowa and Ohio.

[3] Data not shown; adjustment total exceeds the actual amounts paid during the year.

Source: Office of Research and Statistics, Social Security Administration.

Table 10 illustrates the total amount of Federal and State benefit payments from calendar year 1970 to 1987. From 1970 to 1973, these were the benefits under the old-age assistance, aid to the blind, and aid to the permanently and totally disabled programs. For 1988 and 1989, these are estimated payment projections. In fiscal year 1987, Federal benefit payments totaled $9.918 billion and State payments of $2.836 billion.

TABLE 10.—FEDERAL AND STATE BENEFIT PAYMENTS UNDER SSI AND PRIOR ADULT ASSISTANCE PROGRAMS, CALENDAR YEARS 1970–86 AND FISCAL YEARS 1987–1989

[In millions of dollars]

Year [1]	Total	Total constant 1987 dollars	Federal payments	Total State payments	State payments	
					Federally administered	State administered
1970	2,939	8,602	1,801	1,138		
1971	3,206	8,997	([2])	([2])		
1972	3,392	9,215	1,993	1,398		
1973	3,418	8,714	1,987	1,432		
1974	5,246	12,090	3,833	1,413	1,264	149
1975	5,878	12,412	4,314	1,565	1,403	162
1976	6,066	12,111	4,512	1,554	1,388	166
1977	6,306	11,827	4,703	1,603	1,431	172
1978	6,552	11,414	4,881	1,671	1,491	180
1979	7,075	11,078	5,279	1,796	1,590	207
1980	7,941	10,953	5,866	2,074	1,848	226
1981	8,593	10,738	6,518	2,076	1,839	237
1982	8,981	10,575	6,907	2,074	1,798	276
1983	9,404	10,728	7,423	1,981	1,711	270
1984	10,372	11,349	8,281	2,091	1,792	299
1985	11,060	11,685	8,777	2,283	1,973	311
1986	12,081	12,522	9,498	2,583	2,243	340
1987 [3]	12,754	12,754	9,918	2,836	2,484	352
1988 [4]	14,244	[5] 13,741	11,397	3,222	2,850	372
1989 [4]	14,301	[5] 13,310	11,368	3,326	2,935	391

[1] 1970–1973 refers to Old-Age Assistance, Aid to the Blind and Aid to the Permanently and Totally Disabled; 1974–1989 refers to Supplemental Security Income.

[2] Data not available.

[3] Fiscal year outlays.

[4] Fiscal year estimated outlays.

[5] Based on the assumption that the relative increase in the CPI from 1987 to 1988, and from 1988 to 1989, will equal the increase in the CPI from 1986 to 1987.

Source: Office of Research and Statistics, and Office of Financial Resources, Social Security Administration.

NUMBER OF RECIPIENTS: 1970–1991 (PROJECTED)

Table 11 illustrates the changes in the number of individuals receiving assistance under the federally administered SSI program and prior programs. The total number of individuals receiving assistance was 3.1 million in 1970; this increased to 4.3 million in 1975 and declined to 3.9 million in 1982. It is expected to increase to 4.4 million in 1988 and 4.8 million in 1991. The number of aged receiving SSI has declined sharply since 1975 from 2.3 million (or 2.5 million if disabled over age 65 are counted as aged) to 1.5 million individuals in 1986 (2.0 million if disabled over 65 are counted).

The number of disabled receiving assistance increased sharply from 1.0 million in 1970 to 2.0 million in 1975. The number of blind and disabled is projected to be around 3.4 million individuals in 1991.

TABLE 11.—NUMBER OF PERSONS RECEIVING FEDERALLY ADMINISTERED SSI PAYMENTS, 1974–1991; AND ADULT ASSISTANCE UNDER PRIOR PROGRAMS, 1970–1973

[In thousands]

Year [1]	Total [2]	Aged [3]	Blind or disabled		Federal SSI [6]	State supplemental only
			Total [4]	65 and older [5]		
1970	3,098	2,082	1,016			
1971	3,172	2,024	1,148			
1972	3,182	1,934	1,248			
1973	3,173	1,820	1,353			
1974	3,996	2,286	1,710	(7)	(8)	(8)
1975	4,314	2,307	2,007	201	3,893	421
1976	4,236	2,148	2,088	249	3,799	437
1977	4,238	2,051	2,187	302	3,778	460
1978	4,217	1,968	2,249	344	3,755	462
1979	4,150	1,872	2,278	386	3,687	462
1980	4,142	1,808	2,334	419	3,682	460
1981	4,019	1,678	2,341	443	3,590	429
1982	3,858	1,549	2,309	462	3,473	384
1983	3,901	1,515	2,386	485	3,590	311
1984	4,029	1,530	2,499	507	3,699	331
1985	4,138	1,504	2,634	525	3,799	339
1986	4,269	1,473	2,796	540	3,922	348
1987	4,385	1,455	2,930	556	4,019	366
1988 [9]	4,411	1,446	2,965	553	4,046	365
1989 [9]	4,532	1,433	3,099	567	4,155	377
1990 [9]	4,656	1,432	3,234	587	4,268	388
1991 [9]	4,778	1,412	3,366	603	4,380	398

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[1] Data are for December of each year except for 1987–1991 where the data are for March.

[2] All persons with Federal SSI payments and/or Federally administered State supplementation; 1974–1991. For 1970–1973, the total is the number of recipients under the Old-Age Assistance and Aid to the Blind and Aid to the Permanently and Totally Disabled Programs.

[3] For 1970–1973, this column is the number of recipients under the Old-Age Assistance program.

[4] For 1970–1973, this column is the number of recipients under the Aid to the Blind and Aid to the Permanently and Totally Disabled Programs.

[5] For 1974–1991, this is the number of age 65 or older individuals who first received SSI benefits because of being blind or disabled.

[6] All persons with Federal SSI payments include those receiving Federal payments only or both Federal SSI and Federally administered State supplementation.

[7] Data not available for December 1974. In January 1974, there were 87,000 blind and disabled recipients aged 65 or older.

[8] Data not available.

[9] For 1988–1991, these data are projections under current law.

Source: Office of Research and Statistics, and Office of Financial Resources, Social Security Administration.

The number of individuals receiving only Federally administered State SSI benefits steadily declined from 1978 to 1983 as the number of mandatory State supplementation cases declined, but starting with 1984, has steadily increased.

ELIGIBILITY OF SSI RECIPIENTS FOR MEDICAID

States have three options as to how they treat SSI recipients in relation to Medicaid eligibility. Section 1634 of SSI law allows the Social Security Administration to enter into agreements with States to automatically cover all SSI recipients with Medicaid eligibility. SSI recipients are not required to make a separate application for Medicaid under this arrangement. Thirty States have chosen this option, and SSI recipients in these States account for approximately 75 percent of all SSI recipients nationwide.

Under the second option, States elect to automatically provide Medicaid eligibility for all SSI recipients, but only if the recipient completes a separate application with the State agency which administers the Medicaid program. The six States of Alaska, Idaho, Kansas, Mississippi, Nevada, and Oregon, affecting about 2.5 percent of SSI recipients nationwide, have elected this option.

The third and most restrictive option is known as the "209(b)" option, under which States may impose Medicaid eligibility criteria which are more restrictive than SSI criteria, so long as the criteria chosen were part of the State's approved Medicaid State plan in January 1972. 209(b) States may be more restrictive in defining blindness or disability, or more restrictive in their financial requirements for eligibility. Many States use this option to impose stricter transfer of assets or relatives' responsibility requirements than SSI. However, aged, blind, and disabled Medicaid applicants must be allowed to spend-down in 209(b) States, regardless of whether or not the State has a medically needy program. Fourteen States use the 209(b) option for Medicaid coverage of aged, blind, and disabled SSI recipients. About 22 percent of the SSI recipient population nationwide lives in these 209(b) States. The 14 States that use this option are:

Connecticut
Hawaii
Illinois
Indiana
Minnesota
Missouri
Nebraska
New Hampshire
North Carolina
North Dakota
Ohio
Oklahoma
Utah
Virginia

An amendment included in the 1986 SSI disability amendments (P.L. 99-643) required effective July 1, 1987, that 209(b) States continue Medicaid coverage for those SSI recipients who were eligible for Medicaid under a State's more restrictive criteria beginning with the time the individual becomes eligible under Section 1619.

The same legislation required States, effective July 1, 1987, to provide for continued Medicaid coverage for those individuals who lose their eligibility for SSI when their income increases because they become newly eligible for social security benefits as an adult disabled child or because of an increase in their benefits as an adult disabled child. Protection against loss of Medicaid will also be provided for certain blind or disabled individuals who lose their SSI benefits when they qualify for Social Security early aged widow's or widower's benefits beginning at age 60. The 1987 Budget Reconciliation Act provides that such individuals, who otherwise qualify for SSI on the basis of blindness or disability, will be deemed to be an SSI recipient for purposes of Medicaid eligibility until they become eligible for Medicare. This provision will be effective beginning July 1, 1988.

ELIGIBILITY OF SSI RECIPIENTS FOR FOOD STAMPS

Except in California and Wisconsin, SSI beneficiaries may qualify for food stamps if they meet the food stamp income and assets requirements. In these two States, the food stamp program is "cashed out"—in other words, these States have chosen to increase State SSI supplemental payments in lieu of food stamps.

The interaction with the food stamp program has important financial implications for a State which desires to increase the income of its SSI recipients by $1.00. Because food stamps are reduced by $0.30 for each additional $1.00 of SSI income including State supplements, the State must expend $1.43 to obtain an effective $1.00 increase in SSI recipients' total income.

CHARACTERISTICS OF THE SSI POPULATION

As shown in table 12, in December 1987, 4.385 million persons received federally administered SSI payments. Of these, 1.455 million received federally administered payments on the basis of being aged, 2.846 million on the basis of being disabled, and 83,421 on the basis of blindness. However, approximately 556,000 of those receiving benefits on the basis of disability or blindness were over the age of 65. Table 12 also indicates that approximately 2.6 million of those receiving federally administered SSI payments only receive Federal SSI payments, 1,441,145 receive a combination of federally financed and State financed payments, and 365,702 receive State financed supplementation only.

Table 13 shows the trends in the numbers of persons receiving federally administered SSI payments from December 1975 through September 1987, both by reason for eligibility and by age categories. There was a steady decline in the number of SSI recipients from 1975 until 1983. However, in the last 4 years the number of SSI recipients has increased by 453,000.

In summary, the trends in the nature of the SSI population show the following:

—A steady decline in the number of persons receiving SSI benefits on the basis of age.

—A steady increase from 107,000 in December 1975 to 250,000 in 1987 of the number of disabled and blind children under 18 receiving SSI benefits.

—A steady increase from 201,000 in December 1975 to 556,000 in September 1987 in the number of persons receiving benefits on the basis of disability or blindness who were age 65 and older.

—A recent sharp increase of 389,000 between 1983 and 1987 in the number of persons ages 22–64 receiving benefits on the basis of disability or blindness which had been preceded by a decline of 66,000 between 1978 and 1982.

Characteristics of SSI recipients receiving benefits on the basis of age

Age.—As shown in table 14, of those SSI recipients receiving benefits on the basis of age, i.e., age 65 or older, 40.5 percent are 80 years of age or older. This is in contrast to the fact that only 21 percent of the population 65 years old or older are age 80 or older.

Sex.—As shown in table 15, 74.8 percent of those receiving benefits on the basis of age are women.

Race.—Some 20.2 percent of aged SSI recipients are black compared to 8 percent of the total population age 65 and older who are black.

Other income.—As shown in table 16, 71 percent of the SSI recipients receiving benefits on the basis of age also receive Social Security benefits. Only 1.4 percent have earned income.

Characteristics of adult SSI recipients receiving benefits on the basis of disability or blindness

Major disabling diagnosis.—As shown on table 18, of the SSI disabled ages 18–64, 24.3 percent were eligible on the basis of mental retardation; and 26.4 percent on the basis of other mental disorders. Therefore, over one-half of all SSI disabled recipients are eligible on the basis of a mental disability. The next three largest categories are: diseases of the circulatory system—10.4 percent; diseases of musculoskeletal and connective tissues—9.1 percent; and diseases of the nervous system and sense organs—9.0 percent. In comparison, only 24 percent of the Social Security disabled workers are eligible on the basis of a mental disorder; 21 percent of recipient's major disabling diagnosis was circulatory disorders; and musculoskeletal impairments account for 17 percent. Related to the nature of the impairments of the SSI disabled is the fact that in December 1986, 686,614 or 28 percent of the adult disabled receiving SSI benefits had a representative payee. Representative payees are individuals, agencies or institutions selected by the Social Security Administration to receive and use SSI payments on behalf of the SSI recipient when it has been found necessary by reason of the mental or physical limitations of the recipient.

Age.—When a person who is receiving SSI on the basis of blindness or disability becomes age 65, the Social Security Administration does not convert the individual to eligibility on the basis of age. As shown in table 14, 21 percent of the SSI adult population receiving benefits on the basis of disability are over age 65.

Sex.—In September 1987, 58.6 percent of those receiving SSI benefits on the basis of disability and 57.4 percent on the basis of blindness were women.

Race.—In September 1987, 55.9 percent of those receiving SSI on the basis of disability were white; 27.5 percent were black; 4.1 percent were other races; and in 12.5 percent of the cases, race was not reported.

Other income.—As shown in table 16, 37.2 percent of the disabled and 38.7 percent of the blind received Social Security benefits. Table 17 shows the number of SSI recipients with other sources of unearned income.

Of the disabled receiving SSI, 5.2 percent had earned income in September 1987. Of the blind, 6.7 percent had earned income in that month.

Characteristics of disabled or blind children receiving SSI

In a study completed in 1979, it was found that 15 percent of all SSI children were in foster care and under the protective custody of State welfare departments or other social welfare agencies or institutions. For over one-half of these children their main disability was mental retardation. They had lived away from their parents an average of 7.5 years and had little or no contact with their parents. In two-thirds of the cases, the children had been placed voluntarily in foster care by their parents.

For those SSI children not in foster care, 42 percent lived in households that had received AFDC or State or local general assistance during the previous year. For the disabled children not in foster care receiving SSI benefits, mental retardation was the main disability in 27 percent of the cases. Other disabling conditions for this group of children included: other diseases of the nervous system (epilepsy, muscular dystrophy, etc.) 15 percent; other mental conditions (schizophrenia, psychosis, etc.) 15 percent; and congenital anomalies (spina bifida, Down's syndrome and hydrocephalus, etc.) 11 percent.

TABLE 12.—NUMBER OF PERSONS RECEIVING FEDERALLY ADMINISTERED PAYMENTS AND AVERAGE MONTHLY AMOUNT, BY REASON FOR ELIGIBILITY AND TYPE OF PAYMENT, DECEMBER 1987

Type of payment	Total	Aged	Blind	Disabled
	Number of persons			
Total	4,384,999	1,455,387	[1] 83,421	[2] 2,846,191
Federal SSI payments	4,019,297	1,268,123	74,711	2,676,463
Federal SSI payments only	2,578,152	860,865	43,620	1,673,667
Federal SSI and State supplementation	1,441,145	407,258	31,091	1,002,796
State supplementation	1,806,847	594,522	39,801	1,172,524
State supplementation only	365,702	187,264	8,710	169,728
	Average monthly amount			
Total	$251.58	$180.64	$296.67	$286.54
Federal SSI payments	218.39	149.01	239.40	250.67
State supplementation	124.76	124.36	172.45	123.34

[1] Includes approximately 23,000 persons aged 65 or over.

[2] Includes approximately 533,000 persons aged 65 or over.

Source: Office of Research and Statistics, Social Security Administration.

TABLE 13.—SSI: NUMBER OF PERSONS RECEIVING FEDERALLY ADMINISTERED SSI PAYMENTS, BY REASON FOR ELIGIBILITY AND AGE: DECEMBER 1975 AND 1978, JUNE 1982, SEPTEMBER 1983, 1986, AND 1987

[In thousands]

Reason for eligibility and by age categories	December 1975	December 1978	June 1982	September 1983	September 1986	September 1987
Total	4,314	4,217	3,957	3,898	4,232	4,351
Reason for eligibility:						
Aged	2,307	1,968	1,626	1,528	1,476	1,455
Blind	74	77	78	79	83	83
Under 18	3	5	6	6	7	7
18–21	4	3	4	5	5	4
22–64	46	43	44	45	48	49
65 and over	22	25	24	23	23	23
Disabled	1,933	2,172	2,253	2,292	2,673	2,813
Under 18	104	161	188	191	231	243
18–21	90	111	117	122	138	136
22–64	1,559	1,581	1,514	1,517	1,787	1,902
65 or over	179	319	434	462	517	533
Age:						
Under 18	107	166	194	197	238	250
18–21	93	115	121	127	143	141
22–64	1,605	1,624	1,558	1,562	1,835	1,951
65 and over	2,508	2,312	2,084	2,013	2,016	2,010

Source: Office of Research and Statistics, Social Security Administration.

TABLE 14.—NUMBER AND PERCENTAGE DISTRIBUTION OF ALL ADULTS RECEIVING FEDERALLY ADMINISTERED PAYMENTS, BY REASON FOR ELIGIBILITY AND AGE, SEPTEMBER 1987

	Total	Aged	Blind	Disabled
Total number	4,063,243	1,455,081	74,946	2,533,216
Total percent	100.0	100.0	100.0	100.0
18–21	2.5	....	3.9	3.9
22–29	9.2	....	14.4	14.3
30–39	10.3	....	15.5	16.0
40–49	8.6	....	11.2	13.5
50–59	11.9	....	14.9	18.7
60–64	8.0	....	9.8	12.6
65–69	12.2	16.8	8.6	9.6
70–74	11.7	19.8	7.0	7.2
75–79	10.8	22.8	5.9	4.0
80 or older	14.8	40.5	8.7	.2

Source: Office of Research and Statistics, Social Security Administration.

TABLE 15.—NUMBER AND PERCENTAGE DISTRIBUTION OF ALL PERSONS RECEIVING FEDERALLY ADMINISTERED PAYMENTS, BY REASON FOR ELIGIBILITY, RACE, AND SEX, SEPTEMBER 1987

Race and sex	Total	Aged	Blind	Disabled
Total number	4,351,082	1,455,081	83,301	2,812,700
Total percent	100.0	100.0	100.0	100.0
Race:				
White	52.8	46.7	54.9	55.9
Black	25.0	20.2	25.8	27.5
Other	5.1	7.2	5.5	4.1
Not reported	17.0	25.9	13.7	12.5
Sex and race:				
Men	36.0	25.2	42.6	41.4
White	19.4	10.6	24.6	23.8
Black	8.7	4.4	10.3	10.8
Other	2.1	2.4	2.5	1.9
Not reported	5.9	7.8	5.2	4.9
Women	64.0	74.8	57.4	58.6
White	33.4	36.1	30.3	32.1
Black	16.3	15.9	15.5	16.6
Other	3.1	4.8	3.1	2.2
Not reported	11.1	18.1	8.5	7.6

Source: Office of Research and Statistics, Social Security Administration.

TABLE 16.—NUMBER OF PERSONS RECEIVING FEDERALLY ADMINISTERED PAYMENTS AND PERCENT IN CONCURRENT RECEIPT OF INCOME AND AVERAGE MONTHLY AMOUNT, BY REASON FOR ELIGIBILITY AND TYPE OF INCOME, SEPTEMBER 1987

Type of income	Total	Reason for eligibility		
		Aged	Blind	Disabled
Total number	4,351,082	1,455,081	83,301	2,812,700
	Number			
Social security benefits	2,112,810	1,034,307	32,224	1,046,279
Other unearned income	544,358	238,340	10,303	295,715
Earned income	172,556	20,228	5,613	146,715
	Average monthly income			
Social security benefits	$264.05	$269.03	$276.90	$258.73
Other unearned income	88.01	77.04	86.93	96.89
Earned income	156.93	165.54	465.81	143.92

Source: Office of Research and Statistics, Social Security Administration.

TABLE 17.—NUMBER OF PERSONS RECEIVING FEDERALLY ADMINISTERED SSI PAYMENTS AND UNEARNED INCOME (OTHER THAN SOCIAL SECURITY) AND AVERAGE MONTHLY UNEARNED INCOME, BY TYPE OF INCOME, SEPTEMBER 1987

Type of income	Number [1]	Average [2]
Total	544,358	88.01
Veterans' benefits	121,343	135.61
Railroad retirement	6,067	256.67
Black lung benefits	1,886	236.28
Employment pensions	34,767	99.31
Worker's compensation	2,131	206.43
Support and maintenance in kind	156,763	75.94
Support from absent parents	17,508	118.02
Asset income	129,853	9.93
Assistance based on need	11,800	97.95
Other	62,240	148.40

[1] With unearned income other than social security benefits.

[2] Monthly amount of unearned income.

Source: Office of Research and Statistics, Social Security Administration.

TABLE 18.—DISABILITY DIAGNOSIS OF SSI, SECTION 1619, AND SOCIAL SECURITY DISABILITY RECIPIENTS

[Percentage distribution by diagnostic group]

Diagnostic group	Supplemental security income—SSI			Social Security disability insurance—SSDI			
	All SSI disabled 18–64 yrs.[1]	SSI sec. 1619(a) participants[2]	SSI sec. 1619(b) participants[2]	All SSDI disabled workers[3]	SSDI disabled workers under age 40[3]	SSDI disabled widows and widowers[4]	SSDI disabled adult children[5]
Individuals	1,586,700	12,752	15,096	2,712,300	470,500	106,100	550,300
Total percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Infectious and parasitic diseases	.8	.9	.9	1.0	.7	1.6	.9
Neoplasms	1.9	1.7	3.3	3.5	2.6	3.0	.6
Endocrine, nutritional, and metabolic disorders	4.7	1.5	2.2	3.7	2.7	10.1	.5
Diseases of blood and blood-forming organs	.5	.4	.7	.2	.6	.0	.5
Mental disorders (other than mental retardation)	26.4	32.8	35.2	20.1	35.9	17.2	12.5
Mental retardation	24.3	37.0	21.7	4.3	12.0	5.7	62.3
Diseases of:							
Nervous system and sense organs	9.0	15.3	17.9	11.0	15.3	11.3	13.9
Circulatory system	10.4	1.8	3.6	21.3	3.7	22.6	.6
Respiratory system	3.8	.7	.9	5.1	.7	9.9	.3
Digestive system	1.3	.3	.7	1.6	1.3	1.4	.2
Genitourinary system	1.0	1.0	2.1	1.2	1.9	.4	.3
Skin and subcutaneous tissue	.2	...	...	.4	.3	.5	.1
Musculoskeletal system	9.1	2.5	4.2	18.2	7.8	13.5	1.2

TABLE 18.—DISABILITY DIAGNOSIS OF SSI, SECTION 1619, AND SOCIAL SECURITY DISABILITY RECIPIENTS—Continued

[Percentage distribution by diagnostic group]

Diagnostic group	Supplemental security income—SSI			Social Security disability insurance—SSDI			
	All SSI disabled 18–64 yrs.[1]	SSI sec. 1619(a) participants [2]	SSI sec. 1619(b) participants [2]	All SSDI disabled workers [3]	SSDI disabled workers under age 40 [3]	SSDI disabled widows and widowers [4]	SSDI disabled adult children [5]
Congenital anomalies	1.2	1.2	1.5	1.1	1.4	.6	3.6
Injuries	3.8	2.4	4.2	6.8	12.5	1.4	1.9
Other	1.6	.5	.8	.4	.5	.7	.8

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[1] Based on 1-percent sample of those 1,192,100 persons receiving federally administered SSI payments 18–64 years of age in December 1986 but not including 304,000 SSI recipients who were transferred from the pre-SSI State programs for the aged, blind and disabled.

[2] Information on diagnosis of section 1619 participants is available from SSI files only for persons applying since 1982. These data are for September 1987. Percentages shown are based on diagnosis information of 5,533 1619(a) participants and 6,686 1619(b) participants.

[3] Based on 1-percent sample of those 2,460,900 individuals for whom diagnosis information was available of the 2,712,300 disabled workers in current pay status in December, 1986.

[4] Based on 1-percent sample of those 193,000 individuals for whom diagnosis information was available of the 550,300 disabled adult children in current-pay status in December, 1986.

[5] Based on 1-percent sample of those 82,900 individuals for whom diagnosis information was available of the 106,100 disabled widows and widowers in current pay status in December 1986.

Source: Social Security Administration.

SPECIAL SSI BENEFITS, MEDICAID SERVICES, AND RELATED PROVISIONS FOR THE WORKING DISABLED

Historical development of provisions to remove work disincentives for the SSI disabled

Earned income disregards.—Since the inception of the SSI program in January 1974, a portion of the earned income of SSI recipients has been disregarded in determining the eligibility for and the amount of SSI benefits payable. Earned income disregards were included in the pre-SSI federally assisted State programs for the aged, blind, and disabled.

Social Security Disability Amendments of 1980 (P.L. 96-263)—Section 1619 temporary demonstration program.—Prior to the enactment of the section 1619 program in 1980, a disabled SSI recipient who worked faced a substantial risk of losing SSI benefits and frequently, Medicaid. Work was treated the same way it is now treated under the Social Security disability insurance (SSDI) program: after a trial work period, work at the substantial gainful activity (SGA) level led to the loss of disability status and eventually benefits—even if the individual's total income and resources were well within the SSI need criteria. Thus, disabled individuals who could work or, at least, could have tried to work had a disincentive to work because of their fear of losing their SSI benefits or often more importantly their eligibility for health services under Medicaid.

The 1980 amendments established for a 3-year period, beginning January 1, 1981, special provisions under a new section 1619(a) of SSI law, for the provision of special SSI cash benefits to disabled individuals who lost their eligibility for SSI payments because they worked and were declared not disabled. Section 1619(b) provided for special SSI recipient status for Medicaid eligibility purposes for working disabled or blind individuals when they have earnings and their income makes them ineligible for cash payments.

Section 1619 program extended in 1984 and evaluation study conducted.—The Social Security Disability Benefits Reform Act of 1984 (P.L. 98-460) extended the temporary authority of section 1619 through June 30, 1987. At the request of the Committee on Ways and Means, the Department of Health and Human Services conducted a study to evaluate the effectiveness of section 1619 in reducing work disincentives and to determine the characteristics of individuals benefiting from its protection. According to the report, over 55,000 individuals had benefited from the section 1619 program since its inception. The report also indicated that there was a net savings from the provisions of the section 1619 program. The section 1619 report was released July 30, 1986.

Section 1619 made permanent and SSI work incentives simplified.—In 1986, the Employment Opportunities for Disabled Americans Act (P.L. 99-643) made section 1619 permanent and made other modifications in section 1619 and other work-related provisions of SSI law including repeal of the trial work period and extended period of eligibility provisions of SSI disability law.

Establishing SSI disability status and retaining SSI disability status

Establishing SSI disability status—Substantial gainful activity (SGA) determination.—Under the SSI and Social Security disability insurance (SSDI) law, the Secretary of HHS is required to prescribe the criteria for determining when employment or earnings from employment demonstrate an individual's ability to engage in substantial gainful activity (SGA). Current regulations provide that average countable earnings of over $300 a month over an extended period, generally not less than 6 months, indicate that an individual is able to engage in SGA. If an applicant for SSI or SSDI disability benefits has demonstrated the ability to engage in SGA they will not be able to establish an SSI disability status. Current law does provide for a deduction from earnings of extraordinary impairment related work expenses for purposes of determining whether an individual is able to engage in SGA.

Retaining SSI disability status—No SGA determination.—Under the provisions of the 1986 SSI Disability Amendments, Public Law 99-643, disabled individuals on the SSI rolls will retain disability status until they medically recover or their eligibility is terminated for a nondisability reason. A determination that an individual is engaging in substantial gainful activity will not be a factor in retaining SSI disability status. Instead, medical reviews of the individual's disabilities will be conducted to ensure that disability status is not continued for people who have medically recovered. Medical reviews are scheduled based on medical diaries and on work activity. The continuing disability determinations are based on medical improvement criteria.

Repeal of trial work period and extended period of eligibility provisions in SSI effective July 1, 1987

A primary concern with the temporary section 1619 program from its inception in 1981, was the complexity of the various provisions in SSI law which affected the amount of benefits and status of disabled SSI recipients who attempted to work. The section 1619 provisions were in addition to and not a replacement for the trial work period (TWP) and extended period of eligibility provisions in SSI law.

Under the TWP provision a disabled SSI recipient was permitted to work up to 9 months—not necessarily consecutive—before a determination was made as to whether earnings constitute substantial gainful activity (SGA). The TWP provision required determinations by SSA as to whether earnings in a particular month (over $75) constitutes a month of trial work. Eligibility for regular SSI benefits was retained during this time as long as the individual's unearned and earned income (as reduced by income disregards) did not exceed the SSI benefit standard.

When an individual completed a total of 9 months of trial work and was determined to be performing work constituting SGA, he or she lost eligibility for regular SSI benefits 3 months after the 9-month period. If performing SGA was determined, then the individual went into section 1619 status.

Following the close of the trial work period, there was an additional one-time 15 month period (consecutive months; working or not) of an extended period of eligibility (EPE). During this period an individual who had not been receiving a regular SSI payment because of work activities above the $300 SGA level could be reinstated to regular SSI benefit status without having his or her medical condition reevaluated.

The trial work period and extended period of eligibility provisions of SSI law were repealed effective July 1, 1987. As explained earlier, since a determination of whether an individual is engaging in SGA is not a factor in retaining SSI disability status, the trial work period served no practical purpose. The one-time extended period of eligibility was replaced with a provision which allows use, without a one-time limit, of a suspended eligibility status" to protect the disability status of the disabled who attempt work.

The trial work period and extended period of eligibility is still a part of the Social Security disability insurance program and thus affects the SSI disabled who are concurrently eligible for SSI and SSDI. Therefore, a concurrent recipient may retain SSDI during a trial work period but then lose their SSDI benefits. The SSI payments would then increase to make up for the loss of the SSDI benefit.

Summary of section 1619 provisions intended to remove work disincentives for the disabled

Section 1619(a) of SSI law provides for the continuation of cash benefits for those SSI recipients who are receiving benefits on the basis of disability even if they are working and as long as there is not a medical improvement in the disabling condition. The amount of their cash benefits is gradually reduced as their earnings increase under the income disregard formula until their countable earnings reach the SSI benefit standard or what is known as the "breakeven point". In a State with no supplementation, as shown in table 3, this earned income eligibility limit is $793 per month in 1988. People who receive the special SSI benefits continue to be eligible for Medicaid on the same basis as regular SSI recipients. States have the option of supplementing the Federal benefits standard for those entitled to benefits under this provision. The "breakeven point" increases $2 for every $1 of State supplementation above the Federal SSI benefit standard.

Under section 1619(b), individuals can continue to be eligible for Medicaid even if their earnings take them past the SSI income disregard "breakeven point." This special eligibility status, under which the individual is considered a blind or disabled individual receiving SSI benefits for purposes of Medicaid eligibility, applies as long as the individual: (1) continues to be blind or have a disabling impairment; (2) except for earnings, continued to meet all the other requirements for SSI eligibility; (3) would be seriously inhibited from continuing to work by the termination of eligibility for Medicaid services; and (4) had earnings that are not sufficient to provide a reasonable equivalent of the benefits (SSI, State supplementary payments, and Medicaid) that would have been available if he or she did not have those earnings.

In making an initial determination under the fourth criterion, the Social Security Administration decided to compare the individual's gross earnings to a "threshold" amount; i.e., the average expenditures for Medicaid benefits for disabled SSI cash recipients in the individual's State of residence. In other words, Medicaid eligibility continues until the individual's earnings reach a higher plateau which takes into account the person's ability to afford medical care as well as his or her normal living expenses, or they medically recover.

Under the provisions of Public Law 99-643, which was effective July 1, 1987, a disabled individual also has the ongoing protection of being able to be reinstated to eligibility to cash assistance benefits under regular SSI or 1619(a), or Medicaid only eligibility under 1619(b) if their work attempt fails or because of their physical or mental disability makes their ability to work very erratic. This protection is not indefinite, but the Social Security Administration, under the provisions of Public Law 99-643, will not terminate the disability status of an individual for 12 months after they were last eligible for regular SSI or eligible under section 1619(a) or 1619(b). However, if the individual recovers medically a new application and new disability determination would be required to establish a new period of eligibility.

An overview of SSI disability policy changes related to new assumptions for evaluating work efforts by the severely disabled

The section 1619 program was originally enacted as a temporary demonstration program for the purposes of determining whether the continuation of cash and medical benefits for the severely disabled would be effective in lessening the dependence of the disabled on SSI benefits. However, certain provisions of the section 1619 law and the one-time trial work period/extended period of eligibility provisions were still based on the assumption that a continuing work effort by a disabled individual was an indication of the immediate or eventual capability of the individual to become self-supporting. That is, it was assumed that a severely disabled individual would be able to make a steady progression from regular SSI status, to special cash benefit status under section 1619(a), to Medicaid-only status under section 1619(b) and eventually become self supporting.

Section 1619 provisions which expressed this assumption included (1) an individual eligible under 1619(b) who has a decrease in income could not be directly reinstated to cash benefit status; and (2) if an individual has been eligible under 1619 and some event causes him or her to be ineligible for a month, the individual could not return to 1619 status. (Temporary loss of eligibility may occur for example, because of: one-time increases in earnings for a month; excess resources; or changes in living arrangements; e.g., temporary hospitalization.)

A primary goal of the 1986 disability amendments was to ensure ongoing assistance to the severely disabled who are able to do at least some work but who oftentimes have fluctuating levels of income, and whose ability to work changes because of health reasons or the availability of special support services which may be needed to enable the individual to work.

The House and Senate reports accompanying the legislation which became Public Law 99-643 explains the new assumptions which led to the amendments to section 1619 and the repeal of the SSI provisions for a trial work period and extended period of eligibility:

> The Committee amendment also recognizes the reality that severely impaired individuals who make work attempts may not be able to follow a steady progression from SSI status, to special benefit status under section 1619(a), to medicaid only status under section 1619(b), and then to a status of complete independence. In practice, such individuals tend to undergo a more varied experience, often involving some setbacks which would require them to reestablish eligibility for an earlier category of benefits. To accommodate this reality, the Committee provides a relatively simple transition, in either direction, among the various categories of benefits. Actual determination of eligibility are only required in limited and specified circumstances (although the Secretary retains the discretion to review the continuing eligibility of recipients on a periodic basis and whenever there is an indication that there may have been a change in medical condition or other element of eligibility).
>
> Further, the Committee amendment would make explicit in statute the current administrative practice, which requires the filing of a new application for SSI, only in cases where the individual has been eligible for a period in excess of 12 consecutive months. While the 15-month automatic reentitlement period is being eliminated by these amendments, a disabled person who becomes ineligible for SSI or 1619 benefits for a period of 12 or fewer months may be reinstated without having first to be determined disabled.

Characteristics of section 1619 participants

In summary, disabled SSI recipients who work and are eligible for cash benefits and/or Medicaid under the section 1619 provisions of SSI differ from the total population of the SSI disabled by being younger, and more likely to be disabled on the basis of a mental retardation or mental illness. Section 1619(a) refers to recipients who receive special cash and Medicaid while section 1619(b) refers to recipients only receiving continuation of Medicaid coverage.

Age.—As shown in table 19, 43.5 percent of the section 1619 participants are 22–29 years of age compared to 18.1 percent of all disabled SSI recipients between the ages of 18 and 64.

Disability diagnosis.—As shown in table 18, 70 percent of the 1619(a) participants and nearly 57 percent of the 1619(b) participants are eligible on the basis of mental retardation or mental illness. In comparison, approximately 51 percent of the SSI disabled 18 through 64 years of age are eligible on the basis of mental retardation or mental illness.

Concurrent SSI and Social Security disability insurance recipients under section 1619.—Table 20 indicates that 16.4 percent of section

1619(a) participants are concurrent recipients of SSI and SSDI benefits compared to 53.2 percent of section 1619(b) participants and 33 percent of all disabled SSI recipients.

Earnings levels.—Table 21 shows the earnings levels by numbers and percentage distribution of section 1619(a) and section 1619(b) participants. As can be seen from the table, less than 40 percent of section 1619(b) participants have earned income which exceeds the SSI earned income breakeven point in a State without State supplementation, i.e., $793 a month. The fact that 53 percent of the section 1619(b) participants are concurrent SSI and SSDI recipients is a primary reason for this situation. Only $20 a month of Social Security income is disregarded. The result is that an individual with such income becomes ineligible for cash benefits at a much lower total income level than if their income is only in the form of earned income with the higher income disregards, i.e., $85 plus one-half the remaining earnings. For example, a mentally retarded individual receiving SSI whose father is retired and receiving Social Security benefits may qualify as a "disabled adult child" and receive SSDI benefits on his fathers earnings record. If the SSDI benefit is $200 a month, and there is no State supplementation of the $354 Federal SSI benefit standard, when his earnings reach $413 a month he would no longer be eligible for cash benefits under section 1619.

TABLE 19.—AGES OF SECTION 1619 PARTICIPANTS AND SSI DISABLED 18–64; NUMBER AND PERCENTAGE DISTRIBUTION

	All disabled SSI recipients ages 18–64		Section 1619 participants ages 18–64	
	Number	Percent distribution	Number	Percent distribution
Total	2,000,833	100.0	27,591	100.0
Age:				
18–21	98,863	4.9	2,964	10.7
22–29	363,069	18.1	12,008	43.5
30–39	405,213	20.3	7,027	25.5
40–49	341,961	17.1	2,013	7.3
50–59	473,673	23.7	2,335	8.5
60–64	318,054	15.9	763	2.8

TABLE 20.—CONCURRENT SECTION 1619 AND SOCIAL SECURITY DISABILITY INSURANCE RECIPIENTS; NUMBERS AND PERCENTAGE, SEPTEMBER 1987

	Total	Social Security disability recipients	
		Number	Percent
All disabled SSI recipients ages 18–64	1,960,200	655,300	33.4
Section 1619(a) participants	12,752	2,126	16.4
Section 1619(b) participants	15,096	8,035	53.2

TABLE 21.—EARNINGS LEVELS OF SECTION 1619 PARTICIPANTS; NUMBER AND PERCENTAGE DISTRIBUTION, SEPTEMBER 1987

	1619(a)		1619(b)	
	Number	Percent	Number	Percent
Total	12,752	100	15,096	100
Under $300	880	6.9	3,125	20.7
$300–$399	3,991	31.3	1,298	8.6
$400–$499	3,034	23.8	1,102	7.3
$500–$599	2,078	16.3	1,313	8.7
$600–$699	1,313	10.3	1,359	9.0
$700–$799	668	5.2	1,089	7.2
$800–$899	358	2.8	1,551	10.3
$900–$999	189	1.5	974	6.5
$1,000–$1,099	95	.7	902	6.0
$1,100–$1,199	59	.5	463	3.1
$1,200 or more	71	.6	1,927	12.8

Summary of 1986 SSI Disability Amendments to section 1619

The 1986 SSI disability amendments made the section 1619 provisions in SSI law permanent.

The amendments also provided for ongoing assistance for those disabled individuals who, under the old law, which was in effect until July 1, 1987, were in jeopardy of losing their cash benefits or medicaid or the ability to be reinstated to such assistance when there was a significant change in their income or other situation affecting their eligibility.

The amendments to the section 1619 provisions of SSI law can be explained by adding to the pre July 1, 1987 categories of SSI-related eligibility (i.e., SSI, 1619(a), and 1619(b)) the new SSI-related eligibility category of "suspended eligibility status." This new category is a way to identify those individuals who were previously eligible within the last 12 months for SSI or under 1619(a) or 1619(b). Therefore, the categories of SSI-related eligibility under the new law, are as follows:

—eligible for regular SSI cash benefits;

—eligible for cash benefits under 1619(a);
—eligible for Medicaid only under 1619(b); and
—suspended eligibility status; i.e., was eligible within previous 12 months under regular SSI or 1619.

The amendments are based on the assumption that an individual who previously has been found to be eligible for SSI on the basis of disability, but is able to work in spite of a disability, needs ongoing assistance until there is a finding of substantial evidence of medical improvement.

The new general rule for those individuals who previously had been found eligible for SSI disability status is to allow movement to another category or eligibility status. The new rule will allow for freedom of movement from one eligibility status to another when an individual has increases or decreases in earned or unearned income or is otherwise temporarily ineligible under SSI or section 1619 for some other reason.

The changes in present law which were effective July 1, 1987, will provide for this freedom of movement and thus greater assurances of ongoing assistance were as follows:

Repeal of trial work period-extended period of eligibility.—The old law's trial work period and extended period of eligibility provisions were repealed. These provisions had allowed a *one-time-only* reinstatement to regular SSI or section 1619 status if an individual is unable to maintain earnings or otherwise meets the SSI or section 1619 eligibility requirements. As described below, a new "suspended eligibility status" for those previously determined eligible for SSI disability benefits is available to the SSI disabled who are able to work periodically in spite of their impairment.

Reinstatement to SSI or section 1619 status from "suspended eligibility status".—An individual who becomes ineligible for SSI, section 1619(a) or 1619(b) one or more times, is for up to 12 months for each such time of ineligibility, must be considered in a "suspended eligibility status." During any of these times of "suspended eligibility status" an individual can be reinstated to regular SSI or section 1619 status without having to be determined eligible for SSI on the basis of disability as if he or she were a new applicant.

Movement from section 1619(b) medicaid-only status to cash benefit status.—In comparison to prior law, an individual eligible for medicaid only under section 1619(b) who has a decrease in income, can become eligible for cash benefits under section 1619(a) or regular SSI without having to be determined eligible for SSI on the basis of disability as if he or she were a new applicant.

Medical condition reviews.—The new law will explicity require two levels of reviews of the medical condition of the individual when there is movement between the eligibility cagetories: These are:

—within 12 months of an individual becoming eligible under section 1619, a medical review of the individual's case will be required to determine the continuation of the disabling impairment which was the basis of the individual being found to be disabled under SSI.
—promptly after an individual has been reinstated to cash benefit status under regular SSI of section 1619(a) from medicaid-only status under section 1619(b) or reinstated to regular SSI

or section 1619 status from a "suspended eligibility status" certain higher earnings individuals will have a review of medical eligibility to determine that there is no substantial evidence of medical improvement. This "medical improvement review" would apply only to those individuals who had earnings before moving to cash benefit status from section 1619(b) or sometime during the time of "suspended eligibility status" which exceeded the SSI Federal income standard earned income disregards breakeven point; i.e., $793 a month.

Countable earnings and "equivalent" benefits in determining eligibility for Medicaid under section 1619(b).—Effective July 1, 1987, the following costs are to be subtracted from the amount of an individual's earnings in determining whether an individual's earnings provide a "reasonable equivalent" of benefits which the individual otherwise would be entitled to in the absence of earnings: impairment related work expenses of the disabled; work expenses of the blind; cost of a plan for achieving self support (PASS); and publicly funded attendant care services or personal care assistance. It also requires that the "reasonable equivalent" of benefits criteria under section 1619(b), be based on information and data that are updated at least once a year.

TABLE 22.—NUMBER OF PERSONS RECEIVING SSI PAYMENTS, BY STATE, DECEMBER 1987

State	Federally administered				State administered total [2]
	Total [1]	Aged	Blind	Disabled	
Total	4,384,999	1,455,387	83,421	2,846,191	269,763
Alabama	130,955	55,782	1,738	73,435	16,429
Alaska	3,852	1,037	81	2,734	[3] 4,726
Arizona	37,263	10,819	719	25,725	3,762
Arkansas	73,855	31,324	1,310	41,221	....
California	749,748	285,158	20,688	443,902	....
Colorado	32,837	9,097	465	23,275	[3] 19,623
Connecticut	28,806	6,480	530	21,796	17,206
Delaware	7,796	1,885	156	5,755	....
District of Columbia	16,655	3,782	230	12,643	....
Florida	195,969	78,449	3,108	114,412	10,645
Georgia	155,296	56,048	2,778	96,470	....
Hawaii	12,246	5,106	177	6,963	....
Idaho	8,994	1,996	144	6,854	[3] 2,985
Illinois	153,033	30,391	2,391	120,251	51,111
Indiana	53,312	10,922	1,229	41,161	655
Iowa	29,964	8,368	1,081	20,515	....
Kansas	22,385	5,417	353	16,615	....
Kentucky	103,478	31,388	2,076	70,014	6,942
Louisiana	129,099	45,319	2,281	81,499	....
Maine	22,764	7,513	258	14,993	....

TABLE 22.—NUMBER OF PERSONS RECEIVING SSI PAYMENTS, BY STATE, DECEMBER 1987—Continued

State	Federally administered				State administered total [2]
	Total [1]	Aged	Blind	Disabled	
Maryland	55,084	14,310	810	39,964	1,633
Massachusetts	113,825	48,916	4,764	60,145	....
Michigan	129,230	27,521	2,083	99,626	....
Minnesota	35,648	9,593	629	25,426	[3] 11,559
Mississippi	112,807	46,961	1,727	64,119	....
Missouri	81,056	25,080	1,171	54,805	[4] 8,900
Montana	8,525	1,900	136	6,489	....
Nebraska	14,374	3,695	249	10,430	7,571
Nevada	9,115	3,819	511	4,785	....
New Hampshire	6,517	1,606	117	4,794	4,323
New Jersey	97,032	29,355	1,237	66,440	....
New Mexico	27,965	9,268	518	18,179	275
New York	374,968	112,494	4,166	258,308	....
North Carolina	141,523	51,467	2,668	87,388	[4] 13,941
North Dakota	7,045	2,319	86	4,640	16
Ohio	139,357	24,400	2,519	112,438	....
Oklahoma	59,223	22,447	977	35,799	55,618
Oregon	27,625	6,367	582	20,676	13,970
Pennsylvania	173,110	43,138	3,031	126,941	....
Rhode Island	16,331	5,007	206	11,118	....
South Carolina	87,989	31,756	1,836	54,397	2,964
South Dakota	9,114	2,963	138	6,013	325
Tennessee	131,915	45,792	2,018	84,105	....
Texas	269,510	119,202	4,968	145,340	....
Utah	9,916	1,757	226	7,933	8,361
Vermont	9,554	2,813	120	6,621	....
Virginia	88,949	30,333	1,494	57,122	5,280
Washington	52,726	11,287	780	40,659	....
West Virginia	44,118	9,859	692	33,567	....
Wisconsin	79,284	22,700	1,100	55,484	....
Wyoming	2,643	697	52	1,894	[3] 943
Unknown	14	2	....	12	....
Other areas:					
Northern Mariana Islands [3]	600	282	17	301	....

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[1] Includes persons with Federal SSI payments and/or federally administered State supplementation, unless otherwise indicated.

[2] Represents September 1987 data.

[3] Data estimated.

[4] Represents mandatory supplementation data only.

Source: Office of Research and Statistics and Office of Supplemental Security Income, Social Security Administration.

TABLE 23.—STATE SSI SUPPLEMENTS FOR AGED INDIVIDUALS WITHOUT COUNTABLE INCOME LIVING INDEPENDENTLY [1]

State	July 1975	July 1980	Jan. 1985	Jan. 1986	Jan. 1987	Jan. 1988	Percent increase (constant dollars) 1975–88 [1]
Alaska [2]	$142	$235	$261	$269	$292	$305	1
California	101	164	179	197	220	221	3
Colorado	27	55	58	58	58	58	1
Connecticut	NA	NA	NA	NA	NA	393	....
District of Columbia	0	15	15	15	15	15	....
Hawaii	17	15	5	5	5	5	−86
Idaho	63	74	78	72	73	73	−46
Illinois [3]	NA	NA	NA	NA	NA	NA	....
Maine	10	10	10	10	10	10	−53
Massachusetts	111	137	129	129	129	129	−45
Michigan	12	24	27	28	29	30	17
Minnesota [4]	31	34	35	35	35	35	−47
Nebraska	67	75	61	62	51	43	−70
Nevada	55	47	36	36	36	36	−69
New Hampshire	12	46	27	27	27	27	6
New Jersey	24	23	31	31	31	31	−39
New York	61	63	61	72	72	72	−45
Oklahoma	27	79	60	64	64	64	11
Oregon	17	12	2	2	2	2	−94
Pennsylvania	20	32	32	32	32	32	−25
Rhode Island	31	42	54	56	56	59	−11
South Dakota	0	15	15	15	15	15	....
Utah	0	10	10	10	9	9	....
Vermont	29	41	53	56	57	58	−6
Washington [5]	36	43	38	28	28	28	−63
Wisconsin	70	100	100	102	102	103	−31
Wyoming	0	20	20	20	20	20	....
Median [6]	31	43	36	36	36	36	....

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[1] The percentage decrease in constant dollars were computed by inflating July 1975 to January 1988 by the CPI-U price index. The December 1987 figure of 345.7 was used.

[2] 1975 and 1980—less if shelter costs less than $35 monthly.

[3] State decides benefit on a case-by-case basis. In Illinois, the average payment was $57 per month in November 1987.

[4] Payment level for Hennepin County. State has 10 geographic payment levels.

[5] State has two geographic payment levels—highest levels are shown in table. Sum paid in King, Pierce, Kitsap, Snohomish, and Thurston Counties.

[6] Among the States with a payment, Connecticut and Illinois are classified as having a payment above the median.

Source: Office of Research and Statistics and Office of Supplemental Security Income, Social Security Administration.

TABLE 24.—STATE SSI SUPPLEMENTS FOR AGED COUPLES WITHOUT COUNTABLE INCOME LIVING INDEPENDENTLY

State	July 1975	July 1980	Jan. 1985	Jan. 1986	Jan. 1987	Jan. 1988	Percent increase (constant dollars) 1975–88 [1]
Alabama	$9	0	0	0	0	0	−100
Alaska [2]	183	$338	$371	$383	$427	$444	14
California	251	389	448	485	529	534	0
Colorado	133	229	278	284	116	116	−59
Connecticut [3]	NA	NA	NA	NA	NA	602	
District of Columbia	0	30	30	30	30	30	
Hawaii	28	24	9	9	9	9	−85
Idaho	49	80	46	40	44	44	−58
Illinois [3]	NA	NA	NA	NA	NA	NA	
Maine	15	15	15	15	15	15	−53
Massachusetts	173	214	202	202	202	202	−45
Michigan	18	36	40	42	44	45	17
Minnesota [4]	38	44	66	66	66	66	−18
Nebraska	67	114	89	92	78	66	−54
Nevada	106	90	74	74	74	74	−67
New Hampshire	0	42	21	21	21	21	
New Jersey	13	12	25	25	25	25	−10
New York	76	79	76	93	93	93	−43
Oklahoma	54	158	120	128	128	128	11
Oregon	17	10	0	0	0	0	−100
Pennsylvania	30	49	49	49	49	49	−23
Rhode Island	59	79	102	105	106	111	−12
South Dakota	0	15	15	15	15	15	
Utah	0	20	20	20	18	18	
Vermont	61	76	96	101	104	106	−18
Washington [5]	40	44	37	22	22	22	−74
Wisconsin	105	161	161	164	164	166	−26
Wyoming	0	40	40	40	40	40	
Median [6]	57	63	66	66	66	66	

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[1] The percentage decrease in constant dollars were computed by inflating July 1975 to January 1988 by the CPI–U price index. The December 1987 figure of 345.7 was used.

[2] 1975 and 1980—less if shelter costs less than $35 monthly.

[3] State decides benefit on a case-by-case basis. In Illinois, the average payment was $57 per month in November 1987.

[4] Payment level for Hennepin County. State has 10 geographic payment levels.

[5] State has two geographic payment levels—highest levels are shown in table. Sum paid in King, Pierce, Kitsap, Snohomish, and Thurston Counties.

[6] Among the States with a payment Illinois is not classified. Connecticut is classified as having a payment above the median.

Source: Office of Research and Statistics and Office of Supplemental Security Income, Social Security Administration.

Section 10. Title XX Social Services Block Grant Program

TITLE XX SOCIAL SERVICES 1974–1981

In 1974, Congress enacted Public Law 92–672, which created a new title XX of the Social Security Act authorizing an entitlement for States for social services funds with certain goals for the program, public participation planning requirements, limitations on activities which could be funded, and eligibility requirements. Prior to that time the States were entitled to receive Federal matching funds for social services under the various public assistance titles of the Social Security Act. In 1972, Congress established a $2.5 billion annual ceiling on the entitlement with each State's share determined on the basis of its population relative to the total population of all the States. When title XX was enacted, the $2.5 billion ceiling was retained along with the allocation formula. Table 1 shows the title XX funding levels from the first year of the program through present law.

By fiscal year 1981 the entitlement ceiling for allocation to States for social services was $2.9 billion. In addition, $16.1 million of title XX funds was available for the territories for social services and $75 million was available to the States for staff training costs related to title XX activities. A total of $2,991,100,000 was available to States and territories for social services and training in fiscal year 1981 under title XX. As part of Public Law 96–272, enacted in 1980, the ceiling was increased from $2.9 billion to $3 billion in fiscal year 1982 and was increased by $100 million a year until it reached $3.3 billion in fiscal year 1985.

TITLE XX SOCIAL SERVICES BLOCK GRANT

The Omnibus Budget Reconciliation Act of 1981 (Public Law 97–35) amended title XX of the Social Security Act to establish a "Block Grant to States for Social Services" which combined the funding for social services for the States and territories and social services staff training. Public Law 97–35 reduced the title XX entitlement ceiling to $2.4 billion for fiscal year 1982 and provided for increases to $2.45 billion in fiscal year 1983, $2.5 billion in fiscal 1984, $2.6 billion in fiscal 1985 and $2.7 billion in fiscal 1986 and years thereafter.

The emergency jobs bill (Public Law 98–8), enacted in March 1983, appropriated an additional $225 million for fiscal year 1983 but which also was available for carryover to fiscal year 1984. These additional funds were allocated to the States on the basis of a formula intended to respond to the needs of the unemployed served by the jobs bill. One-half of the funds were allocated on the basis of population; one-third based on the number of unemployed individuals in the State; and one-sixth among those States whose average unadjusted unemployment rate from June 1982 through November 1982 was 9.4 percent or higher. In October 1983, as part of legislation to extend the Federal supplemental compensation program (Public Law 98-135) the title XX ceiling was increased by $200 million for fiscal 1984 to $2.7 billion and by $100 million for fiscal year 1985 to $2.7 billion.

Title XX social services block grant funds are allocated to the States on the basis of population. The allotments for Puerto Rico, Guam, the Virgin Islands and the Northern Marianas from the national total are based on their allocation for fiscal year 1981 reduced to reflect the new total funding level. The 1987 Budget Reconciliation Act (Public Law 100-203) extended eligibility for title XX funds to American Samoa. The Federal funds are available to States without a State matching requirement, compared to the 25-percent State matching required for most of the title XX funds available to States under the old title XX law.

Table 1 shows the title XX funding levels since fiscal year 1976 and through the current law's entitlement ceiling for fiscal year 1988 and future years. The table also illustrates these funding levels in constant 1988 dollars. Over the 10-year period (1978 to 1988), title XX funding has declined in real terms by $2,331 million, a reduction of 46 percent. Table 2 shows the total funds available to each State and territory under title XX in fiscal years 1986 through 1989. As part of the sequestration order for fiscal year 1986 under the Gramm-Rudman-Hollings legislation enacted in 1985, there was a reduction of 4.3 percent or $116 million in title XX funds available to States and territories in fiscal year 1986. The allocations to States in fiscal year 1986 in table 2 reflects the reduced funding level.

The allocations to the States shown in table 1 reflect the additional $50 million for fiscal year 1988 and for fiscal year 1989 shows for the first time allocation of funds to American Samoa.

The 1987 Budget Reconciliation Act (Public Law 100-203) included a $50 million increase in the title XX entitlement ceiling for fiscal year 1988. These funds are not yet appropriated. Under present law, the ceiling will return to the $2.7 billion ceiling in fiscal year 1989 and future years. The 1987 act specifically requires that the increased funds are to be used for increased services and not to supplant current State funds for social services.

SPECIAL TITLE XX FUNDING FOR CHILD DAY CARE STAFF AND PARENT TRAINING RELATED TO PREVENTING CHILD ABUSE

Because of the concern by Congress of reports of child sexual abuse in day care centers, a $25 million increase in title XX funding for fiscal year 1985 was appropriated for use by the States in providing training of child day care staff, State licensing and enforcement officials, and the parents of children in child day care. The earmarked funds were included in the continuing resolution for fiscal year 1985 (Public Law 98-473). States were required to have in effect by September 30, 1985, procedures for screening and conducting background and criminal history checks of child care staff, or one-half of the day care training allotment was to be deducted from the regular State title XX allocation in fiscal year

1986 or 1987. According to HHS, only six States enacted such procedures by the required date.

As required by Public Law 98-473, in January 1985, the Secretary of HHS distributed to States a Model Child Care Standards Act with particular attention to staff training and supervision, employment history checks, and parent visitation.

TABLE 1.—TITLE XX SOCIAL SERVICES BLOCK GRANT FUNDING LEVELS

[In millions of dollars]

Fiscal year	Entitlement ceiling	
	Nominal dollars	1988 dollars
1976	[1] 2,575	5,372
1977	[1] 2,796	5,480
1978	[1] 2,791	5,081
1979	[1] 2,991	4,894
1980	[2] 2,791	4,023
1981	[2] 2,991	3,906
1982	[3] 2,400	2,953
1983	[4] 2,675	3,189
1984	2,700	3,087
1985	[5] 2,725	3,008
1986	[6] 2,584	2,799
1987	2,700	2,821
1988	[7] 2,750	2,750
1989 and future years	2,700	2,574

[1] Included $16 million for Puerto Rico, Guam and the Virgin Islands and $59 million in fiscal year 76, $80 million in fiscal year 77 and $75 million in fiscal years 78 and 79 for title XX staff training.

[2] Included $16.1 million for Puerto Rico, Guam, the Virgin Islands and the Northern Marianas and $75 million for title XX staff training.

[3] Public Law 97-35 eliminated separate funding for title XX staff training.

[4] Includes $225 million appropriated in the emergency jobs bill (Public Law 98-8).

[5] Includes $25 million earmarked for training of day care providers, licensing officials and parents including training in the prevention of child abuse in child care settings.

[6] The entitlement ceiling for fiscal year 1986 was $2.7 billion. However, the Gramm-Rudman-Hollings legislation sequestration of funds for fiscal year 1986 reduced the funding by $116 million to $2.584 billion.

[7] $50 million of these funds are not yet appropriated.

TABLE 2.—TITLE XX SOCIAL SERVICES BLOCK GRANT ALLOCATION BY STATE

	Fiscal year—		
	1987 actual	1988 estimate	1989 estimate
Total	$2,698,350	$2,750,000	$2,700,000
Alabama	45,364	46,060	45,145
Alaska	5,661	5,968	5,948
Arizona	34,711	36,507	36,535
Arkansas	26,707	27,022	26,421
California	291,306	302,009	300,531
Colorado	36,050	37,011	36,390
Connecticut	35,859	36,358	35,521
Delaware	6,969	7,125	7,051
District of Columbia	7,068	7,171	6,973
Florida	124,791	130,196	130,043
Georgia	66,363	68,454	67,990
Hawaii	11,813	12,073	11,329
Idaho	11,381	11,512	11,172
Illinois	130,873	132,132	128,685
Indiana	62,215	62,990	61,296
Iowa	33,085	33,036	31,756
Kansas	27,720	28,064	27,412
Kentucky	42,183	42,681	41,525
Louisiana	50,730	51,329	50,135
Maine	13,082	13,334	13,077
Maryland	49,446	50,310	49,712
Massachusetts	65,914	66,690	64,960
Michigan	102,878	104,102	101,863
Minnesota	47,319	48,030	46,938
Mississippi	29,538	29,932	29,239
Missouri	56,938	57,607	56,428
Montana	9,325	9,462	9,123
Nebraska	18,174	18,397	17,800
Nevada	10,310	10,722	10,727
New Hampshire	11,108	11,432	11,439
New Jersey	85,042	86,622	84,876
New Mexico	16,190	16,610	16,474
New York	201,636	203,703	197,956
North Carolina	70,092	71,650	70,519
North Dakota	7,799	7,847	7,563
Ohio	122,244	123,072	119,762
Oklahoma	37,496	37,813	36,813
Oregon	30,402	30,779	30,052
Pennsylvania	135,307	135,775	132,427

TABLE 2.—TITLE XX SOCIAL SERVICES BLOCK GRANT ALLOCATION BY STATE—Continued

	Fiscal year—		
	1987 actual	1988 estimate	1989 estimate
Rhode Island	10,937	11,088	10,860
South Carolina	37,347	38,340	37,604
South Dakota	8,027	8,110	7,886
Tennessee	53,612	54,548	53,499
Texas	180,965	187,517	185,815
Utah	18,782	18,843	18,546
Vermont	6,026	6,128	6,026
Virginia	64,025	65,362	64,459
Washington	49,446	50,505	49,712
West Virginia	22,088	22,177	21,375
Wisconsin	54,187	54,697	53,298
Wyoming	5,783	5,831	5,647
American Samoa	0	0	176
Guam	466	474	466
Northern Mariana Islands	93	95	93
Puerto Rico	13,966	14,224	13,966
Virgin Islands	466	474	466

Source: Department of Health and Human Services.

TITLE XX PROGRAM GOALS

The purpose of the title XX social services block grant program is to provide assistance to States to enable them to furnish services directed at the five goals of the statute:

—Achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency;

—Achieving or maintaining self-sufficiency, including reduction or prevention of dependency;

—Preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating or reuniting families;

—Preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care; and

—Securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions.

States are given wide discretion as to the services to be provided and the groups who may be eligible for services, usually low income families and individuals. In addition to supporting social services, the law allows States to use their allotment for staff training, administration, planning, evaluation, and purchasing technical assistance in developing, implementing, or administering the State social service program. States decide what amount of the Federal allotment to spend on services, training, and administration.

Some restrictions are placed on the use of title XX funds. Funds cannot be used for the following: most medical care except family planning; rehabilitation and certain detoxification services; purchase of land, construction, or major capital improvements; most room and board except emergency short-term services; educational services generally provided by public schools; most social services provided in and by employees of hospitals, nursing homes, and prisons; cash payments for subsistence; child day care services that do not meet State and local standards; and wages to individuals as a social service except wages of welfare recipients employed in child day care.

RECIPIENTS OF TITLE XX FUNDED SOCIAL SERVICES

In fiscal year 1979, when the ceiling on title XX services funds was $2.9 billion, over 7.2 million individuals were recipients of title XX services.

Under the old title XX law, eligibility for title XX funded social services was determined by the States within certain parameters set by Federal law.

The 1981 Budget Reconciliation Act eliminated the federally mandated priority that at least 50 percent of the Federal title XX funds received by a State must be expended for services to recipients of AFDC, SSI or medicaid.

The 1981 Budget Reconciliation Act also eliminated the following provisions in the title XX program related to targeting services to low income individuals and families:

—With certain exceptions, no person with gross family income higher than 115 percent of the State's median income for a family of four (adjusted for family size) could receive title XX funded services. The exceptions were protective services for abused or neglected children or adults, family planning services and information and referral services.

—States had to charge fees reasonably related to income for services to individuals or families with income higher than 80 percent of the State's median income or the median income of all States, whichever was lower, and they could, at their option, charge fees for services to persons below that income level.

While States no longer have to set eligibility standards or target funds within certain parameters set by Federal title XX law, many States have chosen income eligibility criteria lower than the Federal maximum income eligibility limits under the old title XX law. Therefore, it can be expected that the income eligibility criteria that States now use do not exceed that of previous years and most likely are lower because of the reductions in the title XX ceiling.

In fiscal year 1980, 27 percent of those receiving title XX services were AFDC recipients; 11 percent were SSI recipients; 4 percent were medicaid recipients who were not AFDC or SSI recipients; 21 percent of the recipients received services provided without regard to income or welfare status; and 37 percent were eligible according to income criteria.

TYPES OF SOCIAL SERVICES PROVIDED UNDER TITLE XX

Under the title XX social services block grant program each State must submit a report to the Secretary of Health and Human Services on the intended use of the funds. These pre-expenditure reports only are required to include information about the types of activities to be funded and the characteristics of the individuals to be served. Therefore, there is very limited information on the use of title XX funds by the States.

The conference report on the bill providing for the appropriation for title XX funds for 1988 includes a request that prior to the hearing for appropriations for fiscal year 1989, that there be a report submitted to Congress comparing actual fiscal year 1987 expenditures with planned use of fiscal year 1988 appropriations, for all major categories of activities funded through the social services block grant.

Table 3 is a comparison of the primary services offered by the States taken from a summary of the pre-expenditure reports for fiscal years 1982 through 1987 prepared by the Department. Currently, the most frequently provided services are: home-based services, day care for children, protective and emergency services for children and adults, and adoption services. Fiscal year 1979 is the most recent year for which data are available on the percentage of total title XX dollars spent for various types of social services.

In addition to the pre-expenditure reports, another source of data on title XX is from the Voluntary Cooperative Information System (VCIS) of the American Public Welfare Association funded by HHS. The VCIS is a national data base comprised of aggregate State program statistics. Although there are certain limitations to these data, such as unavailability of data for all States, the following presents information on services and recipients for fiscal year 1983, the second year of the SSBG implementation.

Services: Data from 32 States submitting information to the VCIS indicated that the following services accounted for over half of all services provided to recipients: information and referral services, 14.5 percent; protective services for children, 12.3 percent; home-based services, 10.6 percent; counseling, 9.5 percent; and child day care services, 7.5 percent.

Recipients: Data from 32 States show that the number served during fiscal year 1983 was over 5 million recipients.[1]

Homemaker/chore services include, for example, an individual trained by the local welfare agency to go into the home of an aged or disabled individual a few hours a week to assist with meal preparation, cleaning, and personal care to enable them to remain in their home.

Protective services for children include the activities of a child-welfare caseworker who is responsible for investigating and managing cases of child abuse or neglect. For example, a caseworker may visit a home after reports are received from a doctor or a neighbor of possible child abuse and determine whether the home situation

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[1] A Statistical Summary of the VCIS Social Services Block Grant (SSBG) Data for fiscal year 1983. The Voluntary Cooperative Information System (VCIS), American Public Welfare Association. October 1985. pp. 11 and 13.

warrants recommending removal of the children and placement in foster care.

In another situation, the caseworker will have to determine whether the child care training provided by a private family service agency to a teenage mother enables her to care for her two children who currently are in foster care.

TABLE 3.—COMPARISON OF THE NUMBER OF STATES [1] OFFERING SELECTED SERVICES FOR FISCAL YEARS 1982–87

Services	1982	1983	1984	1985	1986	1987
Adoption	43	36	38	37	39	34
Case management [2]						34
Counseling	48	30	28	32	38	33
Day care—adults	41	37	29	26	31	24
Day care—children	54	50	50	52	52	48
Disabled services	24	36	36	39	41	31
Employment, education, and training	40	28	31	31	43	40
Family planning	47	35	31	33	30	31
Foster care—adult	18	25	20	16	18	15
Foster care—children	36	34	34	33	31	30
Health related services	37	26	23	27	36	26
Home based services [3]	54	51	51	55	55	49
Home delivered/congregate meals	28	23	24	24	28	20
Housing services	22	14	12	13	18	9
Information and referral	52	36	34	37	34	25
Legal services	20	17	16	18	17	14
Placement services	27	18	13	19	20	19
Prevention and intervention services [4]		11	28	26	35	31
Protective and emergency—adults	48	44	45	42	46	40
Protective and emergency—children	52	52	47	46	54	46
Residential care—treatment	23	19	26	24	29	25
Special services for children and youth		19	24	22	28	10
Special services for the blind [2]						7
Special services for juvenile delinquents [2]						19
Social support services [5]		2	30	30	25	27
Substance abuse services	14	7	14	14	13	12
Transportation services	36	25	25	29	33	27
Services for unmarried parents	15	10	10	12	10	10
Other [6]		5	27	35	36	7

[1] Includes 50 States, the District of Columbia, and the 4 eligible Insular areas.

[2] Identified as separate service for the first time in 1987. This is not meant to imply that the service was first available in 1987.

[3] Home based services include: homemaker, chore, home health, companionship, and home maintenance.

[4] Prevention/Intervention Services include: Investigation/assessment, family centered early intervention, home evaluation and supervision, preventive and restorative.

[5] Social Support Services include: socialization, recreation, camping, physical activity, living skills, money management, day treatment, family development, social adjustment, community living services, family management, life skills education, personal and financial management.

[6] Other Services include: services to jail inmates or status offenders, social services in correctional facilities, parole supervision, diagnostic and re-entry services to ex-offenders, work release, group home care, and services to Hispanics.

Source: U.S. Department of Health and Human Services—Fiscal Year Preexpenditure Reports.

In another situation, the caseworker may have to arrange for an emergency caretaker to stay with some children in their own home instead of being placed in an institution while their mother is in a hospital receiving emergency medical care.

TRANSFER OF FUNDS AMONG BLOCK GRANTS

Public Law 97-35, which created the title XX block grant, gave States the authority to transfer up to 10 percent of their annual allotment to one or any combination of the four health care block grants and/or the low-income home energy assistance block grant. (The four health care block grants are: the preventive health and health services block grant; the primary care block grant; the maternal and child health services block grant; and the alcohol, drug abuse, and mental health services block grant.) In turn, most other block grant statutes allow States to transfer funds to the title XX program.

According to the fiscal year 1987 pre-expenditure reports submitted to HHS by States, only four States planned to transfer title XX funds to other programs: three States (Alabama, Florida, and Kentucky) planned to transfer funds to the alcohol, drug abuse, and mental health services block grant program, and one State (North Carolina) planned to transfer funds to the maternal and child health block grant program. Eighteen States planned to transfer funds from the low-income home energy assistance block grant to supplement title XX funds.

TITLE XX SOCIAL SERVICES PLANNING AND PROGRAM INFORMATION: PRE-1981 AND NOW

Prior to 1981, the title XX law and regulations required States to publish and make available for public comment a Comprehensive Annual Services Plan (CASP). States were required to make known through public notices the avilability of the CASP and provide opportunity for comment prior to finalizing the plans for the use of the title XX funds.

The law required that the title XX CASP plan include the (1) objectives to be achieved, (2) services to be provided, (3) categories of individuals to be served, (4) geographic areas in which services are to be provided, (5) estimated expenditures, (6) location of resources, (7) coordination with related programs, (8) organizational structure of the administering agency, and (9) planning, evaluation, and reporting activities.

The Comprehensive Annual Services Plan was also sent to the Department of Health and Human Services. Such State plans were the basis of a summary and an analysis of States' planned use of title XX funds which was published by the Department each year until 1980.

While the Comprehensive Annual Services Plan did not allow for an aggregation of the various types and State-defined categories of social services, it did provide in one document a compilation of the States' title XX plans. It allowed for an analysis of States uses of Federal title XX funds for such target groups as the aged, the disabled, and children, and for an analysis of the various types of services which the States had provided for in their title XX funded programs.

In addition to forwarding to HHS their title XX Comprehensive Annual Services Plan, States were also required to provide information to HHS under a system which attempted to provide for a way to aggregate State data into commonly defined categories of social services activities. This system was the Social Services Reporting Requirements (SSRR) and produced reports which aggregated the data from the States and included over 1,000 different State-defined social service categories into 41 Federal categories.

Current Title XX Pre-expenditure Reports

Since 1981, States have only been required to submit to the Department of Health and Human Services, an annual "pre-expenditure report". This financial reporting document (compared to a program plan) provides very minimal information on the uses which States intend to make of their title XX allocations.

In an attempt to determine trends and current expenditures by the States for certain social services categories, HHS was asked to utilize the pre-expenditure reports and summarize expenditures for day care services for children; protective services for children; and home care services. For those three categories, and for only those States that included such services in their reports for fiscal years 1980, 1983, 1986, and 1987, the estimates for their title XX program expenditures for each of those service categories have been listed in table 4.

As can be seen from the data in table 4, there are major changes in a State's reported expenditures for a certain service which, without further clarification, limits the value of the use of only pre-expenditure reports for understanding trends or current expenditures for certain social service categories.

Some States provide as part of the annual pre-expenditure reports a summary of the States intended use of title XX funds similar to the summaries included in the pre-1981 Comprehensive Annual Services Plans. Two examples of these State summaries are included in tables 5 and 6 for the States of Alabama and Pennsylvania. The summaries from both States include estimates of the number of people to be served—Alabama uses monthly numbers and Pennsylvania uses annual numbers. The Alabama summary also includes information on the funds to be transferred from the Low Income Home Energy Assistance block grant and transfer from title XX to the Alcohol, Drug Abuse and Mental Health Services block grant.

TABLE 4.—PRE-EXPENDITURE DATA FOR SELECTED STATES FOR THREE SELECTED SERVICES: FISCAL YEARS 1980, 1983, 1986, AND 1987

[In thousands of dollars]

	1980	1983	1986	1987	Percent change 1980–87
	Home Based Services				
Alabama	5,198	5,478	4,480	2,750	−47
Arkansas	2,018	2,184	1,479	2,071	3
Delaware	509	570	461	420	−17
Georgia	5,227	4,329	3,018	1,858	−64
Illinois	28,690	60,090	26,010	5,622	−80
Indiana	6,630	6,213	7,308	4,130	−38
Iowa	13,004	853	352	465	−96
Kentucky	3,707	2,049	2,219	5,872	58
Mississippi	2,127	2,492	3,182	2,315	9
New Mexico	3,558	2,811	1,888	1,901	−47
South Carolina	4,990	3,625	5,373	3,663	−27
West Virginia	9,224	4,294	5,268	5,736	−38
Wyoming	1,118	911	1,292	1,451	30
	Protective Services for Children				
Alabama	9,843	12,627	13,702	19,114	94
Arkansas	1,561	1,859	2,283	2,256	45
Georgia	8,351	4,445	3,253	6,457	−23
Indiana	6,657	9,662	10,545	8,967	35
Iowa	6,138	7,042	3,806	3,743	−39
Kentucky	4,445	4,697	9,063	11,764	165
Mississippi	1,290	1,784	2,653	3,677	185
New Mexico	1,700	1,951	1,938	3,173	87
Pennsylvania	15,297	2,256	2,526	6,178	−60
South Carolina	5,329	5,806	7,086	5,315	−0
Virginia	6,654	10,962	12,312	14,220	114
West Virginia	3,253	2,703	3,627	3,556	9
Wyoming	68	59	134	1,570	2,209
	Day Care for Children				
Alabama	18,062	10,301	7,699	9,661	−47.0
Arkansas	1,851	1,392	3,238	3,174	71.0
Delaware	4,240	1,862	2,004	2,483	−41.0
Georgia	21,339	14,752	14,117	14,117	−34.0
Illinois	40,911	46,928	40,870	29,426	−28.0
Indiana	9,500	8,435	7,407	7,088	−25.0
Iowa	4,537	2,149	2,969	3,273	−28.0
Kentucky	4,295	3,530	4,171	5,393	−2.6
New Mexico	3,388	2,220	2,241	2,313	−32.0
Pennsylvania	74,811	41,806	42,419	40,289	−46.0

TABLE 4.—PRE-EXPENDITURE DATA FOR SELECTED STATES FOR THREE SELECTED SERVICES: FISCAL YEARS 1980, 1983, 1986, AND 1987—Continued

[In thousands of dollars]

	1980	1983	1986	1987	Percent change 1980–87
South Carolina	12,520	10,923	12,072	9,047	−28.0
Virginia	11,527	6,933	2,937	3,258	−72.0
West Virginia	6,856	4,042	3,700	3,628	−47.0
Wyoming	1,337	1,024	2,328	3,214	140.0

Source: Department of Health and Human Services.

TABLE 5.—ALABAMA: ESTIMATED NUMBER OF CLIENTS AND EXPENDITURES UNDER TITLE XX BLOCK GRANT FOR SOCIAL SERVICES, FISCAL YEAR 1987

[Dollars in thousands]

Service	Estimated number served monthly	Title XX estimated expenditures	Total estimated expenditures
Adoption services	878	$338	$985
Day care/day health for adults	725	1,205	1,205
Day care for children	6,500	1,349	9,662
Foster care for adults	127	163	163
Foster care for children	6,684	10,613	12,089
Homemaker services for adults	3,100	2,652	2,724
Homemaker services for children	480	98	191
Preventive and supportive services	1,750	500	675
Protective services for adults	2,900	3,846	5,940
Protective services for children	6,400	19,114	25,451
Residential care for delinquents	60	562	737
Residential care for individuals with exceptional needs	400	3,338	3,407
Total mental health transfer [1]		2,500	
Total		[2] 46,274	[3] 63,228

[1] Transfer of $2.5 million to Alcohol and Drug Abuse and Mental Health Services Block Grant.

[2] Includes $915,000 million transfer from Low Income Energy Assistance Block Grant.

[3] Includes Federal, State, and local funds.

TABLE 6.—PENNSYLVANIA: ESTIMATED TITLE XX FUNDS AND PERSONS SERVED BY PROGRAM AREA AND SERVICE, FISCAL YEAR 1987

[Dollars in thousands]

Service	Estimated Federal funds	Estimated persons to be served (annually)
Adult day care	$1,047	644
Attendant care	4,506	690
Child welfare social service	6,178	1,917
Community residential mental retardation service	5,579	359
Community residential rehabilitation	2,080	1,069
CAO—support service	9,349	201,039
County social services	32,137	353,463
Employment	5,841	135,326
Family planning	5,020	83,790
Family support service	1,551	1,273
Information and referral	2,296	212,448
Legal	6,688	40,000
Protective—domestic violence	1,348	11,396
Protective-emergency shelter	2,876	35,471
Protective—rape crisis	834	11,503
Service planning/case management	2,746	41,562
Subsidized child day care	40,289	13,430
Transportation	46,764	1,309
Administration	5,436	
Total	135,847	1,146,689

Section 11. Child Welfare, Foster Care and Adoption Assistance Program—Title IV, Parts B and E

In 1985, State and local agencies received reports of nearly 2 million cases of suspected child abuse or neglect. During fiscal year 1985 nearly one-half million children spent some time in foster care. An estimated $1.8 billion of funds authorized under the Social Security Act will be spent for child welfare, foster care and adoption activities in fiscal year 1988.[1]

HISTORICAL DEVELOPMENT OF CHILD WELFARE PROGRAMS

Many of the original Thirteen Colonies had laws against certain forms of child maltreatment. However, a private voluntary agency, the New York Society for the Prevention of Cruelty to Children, was the first specialized child protective agency in 1875. By the 1920's, most States had passed specific laws against child maltreatment, often within the context of their newly established juvenile courts.

Child Welfare Services in the Social Security Act of 1935

Within the context of broader concerns about the deprivation of families and children in the Depression of the 1930's, the original Social Security Act authorized grants to States for child welfare services which were intended to assist in the development of organizational structures for the delivery of child welfare services.

AFDC Foster Care—1961

Federal matching funds for foster care maintenance payments for AFDC children placed in foster care was authorized in 1961 and eventually became a required component of States' AFDC program. It was established in response to some States denying a family AFDC benefits when a child's home was found to be unsuitable.

1962 Social Services Amendments

As part of the amendments which emphasized the use of social services to prevent the need for dependence on cash assistance welfare programs, the 1962 amendments required that each State extend child welfare services to all political jurisdictions within the State.

Title XX Social Services Amendments

Protective services for children was one of the goals of the $2.5 billion title XX social services legislation which was enacted in 1974. These funds are the largest single source of Federal funds for child welfare services, with at least 20 percent used for child welfare activities by the States.

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[1] Includes an estimated $600 million of funding under title XX.

Child Abuse and Neglect Reporting Laws

During the 1960's, nearly all the States enacted State laws patterned after a "model state law" published by the U.S. Childrens Bureau which required physicians to report suspected cases of child abuse and neglect. The Child Abuse Prevention and Treatment Act of 1974 provided Federal funds to States that established comprehensive child abuse and neglect reporting and investigatory systems.

Adoption Assistance and Child Welfare Amendments of 1980 (P.L. 96-272)

The AFDC foster care program and a new program of Federal matching funds of adoption assistance for "special needs" children were included in a new title IV-E of the Social Security Act. Financial incentives were included related to increased funds under the title IV-B child welfare services program to encourage States to have certain services and procedures to prevent inappropriate use of foster care.

Independent Living Programs for Older Foster Children

The 1985 Budget Reconciliation Act established a new program of grants to States for assisting older foster children prepare for independent living.

SUMMARY OF FEDERAL FUNDING OF CHILD WELFARE, FOSTER CARE, AND ADOPTION ACTIVITIES UNDER THE SOCIAL SECURITY ACT

The Social Security Act contains four primary sources of funds available to States for child welfare, foster care, and adoption activities. These funds include both nonentitlement authorizations and authorized entitlements; i.e., a State is entitled to claim Federal matching funds for those activities which qualify under the requirements of the Federal law. Those programs are:

- —Title IV-B Child Welfare Services program (nonentitlement authorization)
- —Title IV-E Foster Care program (authorized entitlement)
- —Title IV-E Adoption Assistance program (authorized entitlement)
- —Title XX Social Services Block Grant (authorized entitlement with funding ceiling; State discretion as to portion of State's allocation used for child welfare and adoption activities)

Table 1 shows the funds that have been used or allocated to States under titles IV-B and IV-E in fiscal years 1981 through 1986 and the estimated amounts for fiscal years 1987 and 1988. Under the title XX Social Services Block Grant program, States may choose what portion of their allocation they will spend on child welfare, foster care and adoption activities, as well as other activities not directly focused on children. Under the fiscal year 1988 title XX $2.75 billion ceiling, it is estimated that about $500 million of title XX funds are spent on such services.

In addition to the funds allocated to the States or available on an entitlement basis, approximately $15 million was appropriated for fiscal year 1988 for activities authorized under Section 426 of title IV–B for direct Federal grants to public and private entities for child welfare staff training and child welfare research and demonstration projects, of which $2.4 million was reprogrammed for general social services research.

Funds available to States from the title IV–B child welfare program and the title XX Social Services program may be used for services to families and children without regard to their eligibility for AFDC. Federal matching funds for foster care maintenance payments under title IV–E are only provided in those cases where the child would have been eligible for AFDC if still in the home. All children determined to have "special needs" related to their being adopted are eligible for certain kinds of assistance under the title IV–E adoption assistance program.

TABLE 1.—FEDERAL FUNDING FOR CHILD WELFARE, FOSTER CARE, AND ADOPTION ACTIVITIES UNDER TITLES IV–B AND IV–E OF THE SOCIAL SECURITY ACT, 1981–89

[In thousands of dollars]

Fiscal year	Title IV–E, Independent Living Program	Title IV–B, Child Welfare Services[1]	Title IV–E, Foster Care State Claims	State use of FC Funds for IV–B, CWS	Adoption Assistance, title IV–E	Total, titles IV–B and IV–E
1981		163,550	308,777	74,109	486	546,922
1982		156,326	373,849	20,560	4,735	555,470
1983		156,326	391,265	32,608	12,564	592,763
1984		165,000	463,946	32,176	25,223	686,345
1985		200,000	531,535	[4]19,592	42,344	793,471
1986		[2] 198,099	[3] 612,781	[4]14,896	54,518	880,294
1987 (est.)	45	222.5	690,314	11,345	71,634	1,040,793
1988 (est.)	45	239.35	760,070	6,990	109,969	1,161,379
1989 (est.) [5]	45	239.35	825,033	7,008	133,936	1,250,327

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[1] States that had not been determined by HHS to have implemented Section 427 protections, received about 10 percent less funds that would have been their allocation under the appropriation for fiscal years 1982 and 1983, 15 percent less in fiscal year 1984 and 30 percent less in fiscal year 1985. Public Law 96–272 requires HHS to reallocate such funds to those States that do meet the Section 427 requirements for the year.

[2] Funding level for fiscal year 1986 reflects a 4.3 percent reduction in the $207 million IV–B child welfare funds appropriated due to the sequestration of 4.3 percent of the funds under the Gramm-Rudman-Hollings legislation.

[3] Funding level for title IV–E foster care includes a $6 million reduction from funds that would otherwise have been provided to States because of the denial of Federal matching of State increases in foster care payment rates required under the fiscal year 86 sequestration order under the Gramm-Rudman-Hollings legislation.

[4] Reduction from previous years in the amount transferred is due largely to the increase in title IV–B appropriation which limits the amount that a State can transfer under an "optional" ceiling to the additional amount that a State would have received if the IV–B appropriation was the full authorization of $266 million.

[5] Authorized only through fiscal year 1988.

OVERVIEW OF FEDERAL AND STATE ROLES IN CHILD WELFARE ACTIVITIES

The basic governmental responsibility for responding to children in need of some form of protection from harm or neglect is with the individual States.

The Federal role in the overall governmental response to child abuse or neglect has been primarily by way of making available Federal matching funds to States for certain specific activities and programs. To qualify for such funds States have to: establish certain administrative structures; provide certain services; entitle certain individuals to assistance; or establish certain due process and review procedures.

Each State has its own mix of legal authority and child welfare administrative procedures and services that is utilized in responding to reports of child abuse or neglect and in responding to families and children referred to a governmental agency because of needs related to delinquency, homelessness or family conflict.

Figure 1 on the following page attempts to illustrate the interrelationships among:

—States' legal authority in their child abuse and neglect laws;

—The alternative courses of action which can be taken in response to children who have been reported as abused or neglected or otherwise referred for services to the responsible agency and;

—The Federal foster care and child welfare law services and procedures requirements of the 1980 Act—P. L. 96–272.

In addition, included in the flow chart are estimates of the number of children in fiscal year 1985 who entered the system and what action was taken—if such information is known.

COMPONENTS OF STATE CHILD ABUSE AND NEGLECT LAWS

Every State has laws authorizing designated governmental agencies and the courts to investigate reports of suspected child abuse or neglect and to intervene into the relationship between a child and their parents in cases of abuse or neglect.

In all States, the statutory approach to child abuse and neglect contains the following basic components: identification; investigation; and intervention.

Identification

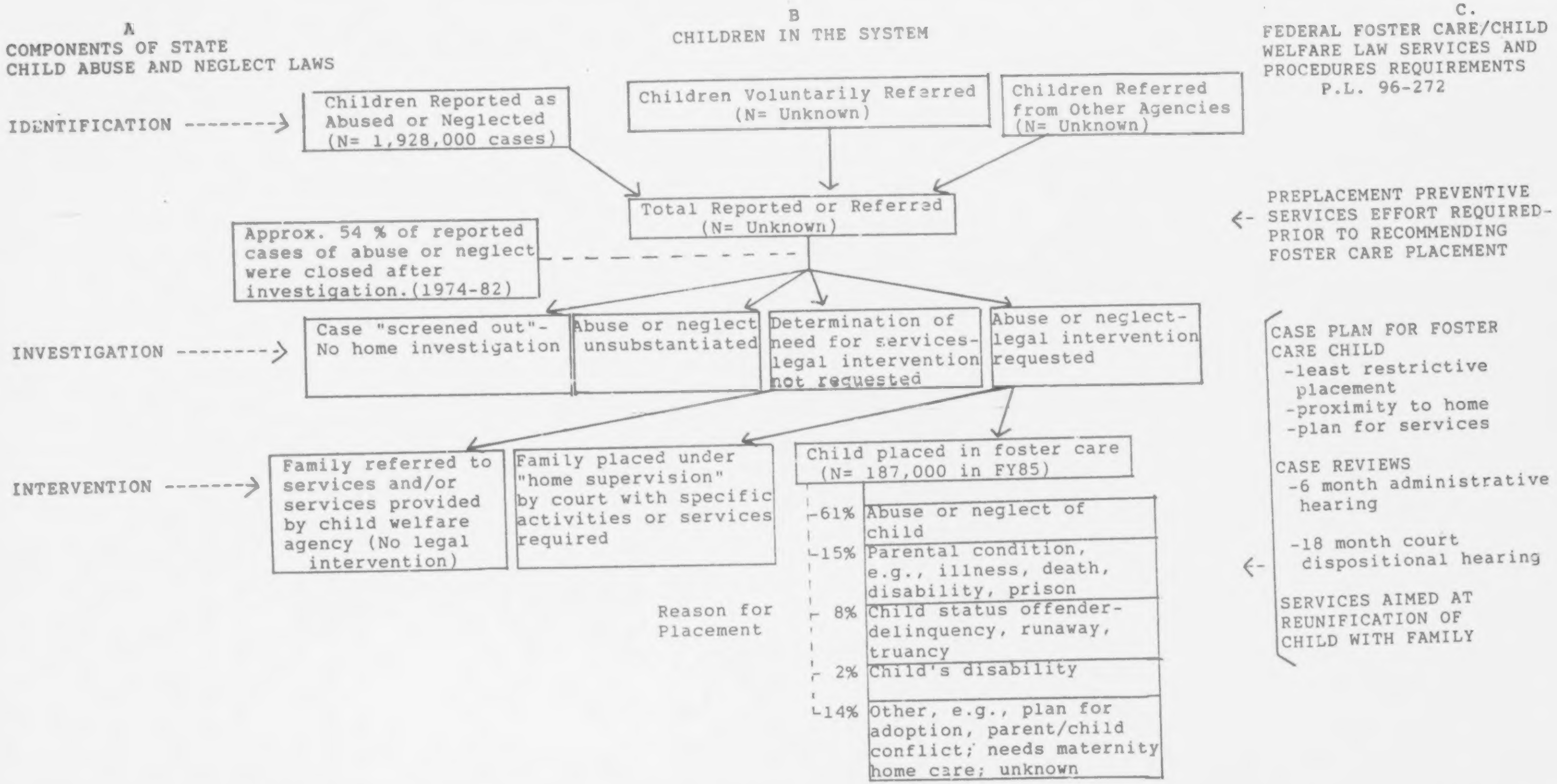
All States have some statutory provision for mandatory reporting of non-accidental injury and neglect of children. These provisions generally include:

Definitions of reportable conditions.

Persons required to report.—Those required to report include, e.g., physicians; nurses; social workers; child care workers; and police officers.

"Hotlines".—States have 24-hour-a-day telephone "hotlines" as a means for others in the community to report suspected cases of abuse or neglect.

Figure 1. CHILDREN ENTERING CHILD WELFARE AND FOSTER CARE PROGRAMS - FY 85


A
COMPONENTS OF STATE CHILD ABUSE AND NEGLECT LAWS
B
CHILDREN IN THE SYSTEM
C.
FEDERAL FOSTER CARE/CHILD WELFARE LAW SERVICES AND PROCEDURES REQUIREMENTS P.L. 96-272
IDENTIFICATION
Children Reported as Abused or Neglected (N= 1,928,000 cases)
Children Voluntarily Referred (N= Unknown)
Children Referred from Other Agencies (N= Unknown)
Total Reported or Referred (N= Unknown)
PREPLACEMENT PREVENTIVE SERVICES EFFORT REQUIRED-PRIOR TO RECOMMENDING FOSTER CARE PLACEMENT
Approx. 54 % of reported cases of abuse or neglect were closed after investigation.(1974-82)
INVESTIGATION
Case "screened out"- No home investigation
Abuse or neglect unsubstantiated
Determination of need for services-legal intervention not requested
Abuse or neglect-legal intervention requested
INTERVENTION
Family referred to services and/or services provided by child welfare agency (No legal intervention)
Family placed under "home supervision" by court with specific activities or services required
Child placed in foster care (N= 187,000 in FY85)
Reason for Placement
61%
Abuse or neglect of child
15%
Parental condition, e.g., illness, death, disability, prison
8%
Child status offender-delinquency, runaway, truancy
2%
Child's disability
14%
Other, e.g., plan for adoption, parent/child conflict; needs maternity home care; unknown
CASE PLAN FOR FOSTER CARE CHILD
-least restrictive placement
-proximity to home
-plan for services
CASE REVIEWS
-6 month administrative hearing
-18 month court dispositional hearing
SERVICES AIMED AT REUNIFICATION OF CHILD WITH FAMILY

Source: Voluntary Cooperative Information System, American Public Welfare Association, through a grant from the Department of Health and Human Services.

Investigation

State laws designate those public agencies with the legal authority to investigate reports of child abuse or neglect and generally include a public social services agency, an agency with responsibility related to youth and the police. There are variations in the requirements in State laws and policies as to the allowable time lapse between the time of the receipt of the report and the home investigation. Generally, cases involving older children reported to have been neglected have a longer required response time in comparison to cases of alleged abuse of younger children—especially sexual abuse.

The agency which receives the reports generally has the following options:

"Screen out" the report.—In most States some criteria as been established to determine those reports not warranting home investigation.

Unsubstantiated report.—The agency investigates the report and based on information gathered determines no need for further action or services and case is closed. (As discussed later, definitions of "substantiated" varies considerably from State to State and in actual practice within a State.)

No abuse or neglect/services needed.—The agency makes a home investigation and finds insufficient evidence to indicate abuse or neglect but does determine a need for social services or other assistance by the family.

Abuse or neglect found/legal intervention needed.—The agency investigates and determines that there is sufficient evidence that abuse or neglect has taken place and that some legal action is needed for emergency and/or long term intervention by the agency and the courts.

Intervention

Intervention into the actual relationship between a child and their parents or legal caretaker may, with considerable variation among the States, take one of the following forms:

Emergency removal of the child.—There is considerable variation among the States as to who has authority for the emergency removal of a child from the home for short term placement in cases of emergency; e.g., life threatening or severe injury cases. A HHS study of the practices in the three States of Colorado, New York, and Texas indicated these differences. In Colorado, the police can remove a child but a child welfare worker must have a court order. If the child is removed by a "police hold" a petition must be filed with the court within 48 hours. In New York, the caseworker in conjunction with the police can immediately remove a child, but a petition must be filed with the court the next day. In Texas, the child welfare worker may remove a child without the police, but must file a petition with the court within 48 hours.

Court-ordered "home supervision."—In some States, the result of a family or juvenile court finding that a child has been "neglected" may be that the court orders agency supervision of the family's home life, counselling for the parents or child or other social services.

Court-ordered removal of the child from the home and placement in foster care.—All States have laws which provide for the removal of a child from their home and placement in foster care pursuant to "a judicial determination that continuation in the home would be contrary to the welfare of the child."

CHILDREN REPORTED AS ABUSED OR NEGLECTED OR REFERRED TO CHILD WELFARE AGENCIES

As shown in figure 1, in fiscal year 1985, over 1.9 million cases of suspected child abuse and neglect were reported to child welfare and other agencies responsible for receiving such reports. This is more than double the number of reported cases of 669,000 for 1976. These estimates are developed by the American Humane Association under a contract with HHS as part of the annual National Study on Child Abuse and Neglect. The study is based on a voluntary information system whereby States are asked to provide information on reports they have received on suspected abuse and neglect.

In a report prepared by the American Humane Association under a contract with HHS in 1984, the lack of a uniform definition of what is a "substantiated" case of child abuse or neglect was cited as the major definitional problem in the field of child protective services. The report stated that, a substantiated case in some instances is a case that has been or could be adjudicated in a court under the laws of the State as being child abuse or neglect; in others, it means that the case worker determined that a case file should be established for the family; i.e., that some type of services are needed whether or not the case could be found in a court as meeting the definition of abuse or neglect. For this reason, the 1984 study by the American Humane Association chose not to include substantiation rates.

As indicated in figure 1, and according to the 1984 American Humane Association report, 54 percent of the cases that were investigated for the period of 1976–82 were closed after investigation, 36 percent were provided with services and the remaining 10 percent were still under investigation at the time the report was made by the agency. The 1984 report stated that while abuse and neglect reports increased over the years resources and staff did not.

There are no reliable numbers regarding the number of children voluntarily referred by parents or referred by other agencies. However, it appears that there is considerable variation among the States as to the role of the public child welfare agency in the State related to the care of children who come into care through the juvenile justice system, or are in care because of the mental or physical handicap of the child.

An HHS study compared practices in three counties in three different States—Dallas County, Texas, Jefferson County, Colorado, and Monroe County, New York. In New York and Colorado, children who came to the attention of the juvenile justice agency but were not judged to require a secure detention facility, were referred to the child welfare agency for placement. In contrast, in Dallas County, Texas, the child welfare agency did not accept children referred by the juvenile justice agency nor did they accept children whose parents wished to place them in foster care. The result was the average age of children entering foster care in Dallas County was 6 compared to 11 years of age in Jefferson and Monroe County.

CHILDREN IN FOSTER CARE

Figure 2 shows the number of children in foster care sometime during fiscal year 1985 totaled 452,810. The following information regarding the characteristics of children in foster care is based on the information gathered through the Voluntary Cooperative Information System (VCIS) operated by the American Public Welfare Association and financed by a grant from the Department of Health and Human Services. The data gathered through VCIS is not limited to children for whom States claim Federal matching funds under the title IV-E foster care program. Instead, the data represent estimates (based on reports from a limited number of States) of all the children in foster care or substitute care; i.e., residing outside their home under the case management and responsibility of the primary State child welfare agency, or a child placing agency under contract with the State.

As shown in figure 1, of the 187,000 children placed in foster care or substitute care in fiscal year 1985, an estimated 61 percent were placed because they had been abused or neglected. Some 15 percent of the children in foster care were placed because of a parental condition, such as, the parent's illness, handicap, incarceration or the death of the child's parents. The child's disability was the reason for placement in 2 percent of the cases. The child was placed in foster care or substitute care because they were a status offender, e.g., runaway, delinquent behavior, in 8 percent of the cases in 1985. The remaining 14 percent of the cases involved such situations as: a plan for adoption; a parent-child conflict; or the need for maternity home care.

It should also be noted that approximately 30 percent of the 187,000 children shown as entering foster care in fiscal year 1985 had been in foster care before and had been, for example, reunified with their families or placed in adoption but such a placement had not been successful.

In fiscal year 1985, of the children who entered foster care, 48 percent were 11 years of age or older; 58 percent of the children entering foster care in 1985 were white; 23 percent were black; 11 percent were hispanic; 1 percent were American Indian or Alaskan, and 1 percent were Asian.

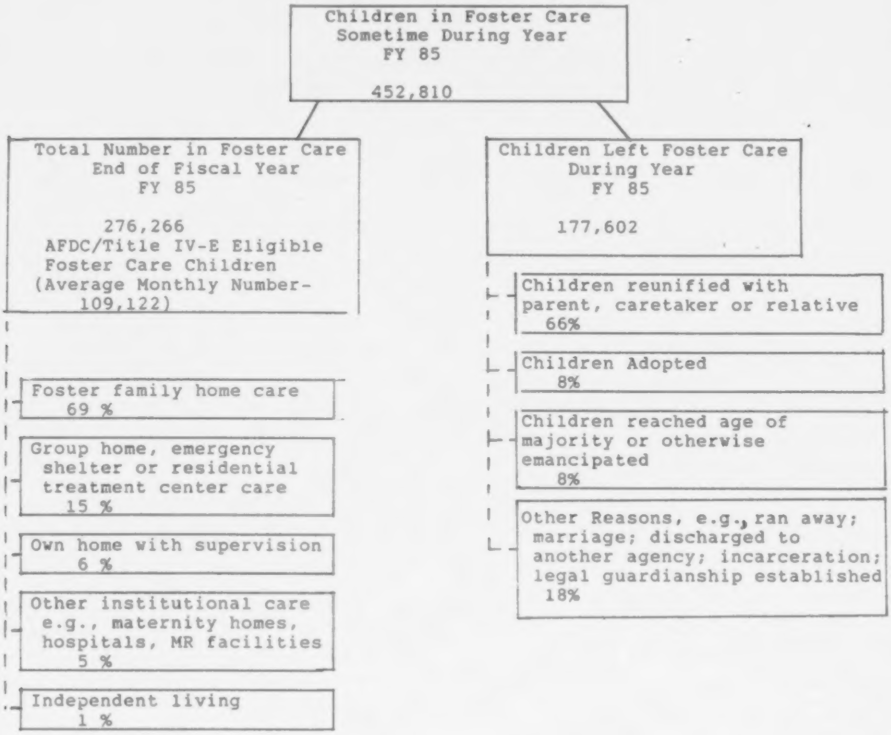
As shown in figure 2, of the 276,266 children in foster care during the last month of fiscal year 1985, 69 percent were in foster family home care. Group homes, emergency shelters and residential treatment center care accounted for 15 percent of the children in foster care at that time. Other institutional care, such as maternity homes, hospitals and facilities for the mentally retarded was the placement for 5 percent of the children in foster care under the care or supervision of the State child welfare agency administering the States' foster care programs. The other categories of foster care are the 6 percent of the children who were classified as being in foster care but were in their own home but under supervision, and the 1 percent in independent living.

During fiscal year 1985, as shown in figure 2, 177,602 children left foster care. Of the children who left foster care, 66 percent were reunified with their parents, relative or caretaker. Eight percent of the children who left foster care were placed for adoption or had their adoption finalized. Another 8 percent left foster care because they reached the age of majority. The other 18 percent of the children who left foster care during fiscal year 1985 left for such other reasons as: incarceration; running away; being discharged to another agency or they were placed in legal guardianship.

In most States, the level of payment for foster family care varies by the age of the child and whether there are special needs of the child. In 1986, for a 9-year-old child in foster care the monthly rate was: between $150 and $199 in 10 States; between $200 and $249 in 23 States; between $250 and $299 in 10 States; and over $300 in 8 States.

In some teenage foster care cases, the foster child is herself the parent of an infant child who lives in the same foster home or a specialized residential program for teen mothers and their infants. The infant is not eligible for federally assisted foster care because they are living in the same home or institution as the parent. The 1987 Budget Reconciliation Act required, that, effective April 1, 1988, States would be required to include in the foster care payment rate for the teenage mother, an amount equal to the rate payable for the foster care teenage mother plus the foster care rate payable as if the infant was eligible for foster care in their own right in the same foster care setting.

Figure 2. CHILDREN IN FOSTER CARE - FY 85
Types of Foster Care; Reasons for Leaving Foster Care


Children in Foster Care Sometime During Year FY 85
452,810
Total Number in Foster Care End of Fiscal Year FY 85
276,266
AFDC/Title IV-E Eligible Foster Care Children (Average Monthly Number- 109,122)
Foster family home care 69 %
Group home, emergency shelter or residential treatment center care 15 %
Own home with supervision 6 %
Other institutional care e.g., maternity homes, hospitals, MR facilities 5 %
Independent living 1 %
Children Left Foster Care During Year FY 85
177,602
Children reunified with parent, caretaker or relative 66%
Children Adopted 8%
Children reached age of majority or otherwise emancipated 8%
Other Reasons, e.g., ran away; marriage; discharged to another agency; incarceration; legal guardianship established 18%

Source: Voluntary Cooperative Information System, American Public Welfare Association, through a grant from the Department of Health and Human Service.

TITLE IV-E FOSTER CARE PROGRAM

The title IV-E foster care program is an authorized entitlement under which States can claim Federal matching funds for their expenditures for foster care maintenance payments and related administrative costs for the care of certain children.

Matching and Eligibility Requirements

Federal matching for foster care maintenance payments is the same percent as the State can claim for AFDC payments which ranges from 50 percent to 78 percent and which is inversely related to the per capita income of the State. Federal matching for administrative costs is 50 percent.

States may claim Federal matching funds under title IV-E only for that portion of their foster care program which provides care for AFDC related children; i.e., children who except for their being removed from their home and being placed in foster care would be eligible for AFDC. Current HHS regulations give the following examples of allowable administrative costs for the foster care program: referral to services; preparation for and participation in judicial determinations; placement of the child; development of the case plan; case reviews; case management and supervision; recruitment and licensing of foster homes and institutions rate setting; and a proportionate share of agency overhead.

Number of Title IV-E Foster Care Children and Program Costs

As shown in Table 1, States' claims for Federal matching funds for foster care is expected to increase from $309 million in fiscal year 1982 to an estimated $825 million in fiscal year 1989.

Table 2 provides State-by-State information on the monthly average number of children that States have, or are expected to claim Federal matching for, in fiscal year 1987. In fiscal year 1987 the number was an estimated 112,743 and has increased gradually from 97,360 in fiscal year 1977. As discussed earlier, the number of children in foster care in the States in the last month of fiscal year 1985 was 276,266. Therefore, States claim Federal matching funds for approximately 37 percent of the children in foster care. This percentage varies considerably among the States depending on such factors as to whether the States provide AFDC benefits under the AFDC unemployed parent program and thus expand the potential eligibility under the AFDC foster care program.

TABLE 2.—TITLE IV-E FOSTER CARE: EXPENDITURES; TITLE IV-B TRANSFERS; NUMBER OF CHILDREN—FISCAL YEAR 1987

State	Fiscal year 1987 Foster Care expenditures	IV-B transfer	Fiscal year 1987 average monthly number of children
Alabama	1,979,717	600,000	1,339
Alaska	405,956		61
Arizona	3,121,912		544
Arkansas	1,115,324		389
California	154,075,568		23,706
Colorado	3,895,694		1,550
Connecticut	4,060,019		1,144
Delaware	396,037	99,387	242
District of Columbia	3,722,328		289
Florida	5,386,764		1,582
Georgia	10,329,324		2,113
Hawaii	76,228		41
Idaho	284,878	245,570	161
Illinois	25,357,157		5,754
Indiana	1,208,788	1,094,653	1,359
Iowa	3,525,473	413,768	1,143
Kansas	4,182,419		1,067
Kentucky	7,120,661		1,521
Louisiana	13,297,484		2,497
Maine	4,119,038		682
Maryland	11,826,743		1,192
Massachusetts	5,174,976		900

TABLE 2.—TITLE IV–E FOSTER CARE: EXPENDITURES; TITLE IV–B TRANSFERS; NUMBER OF CHILDREN—FISCAL YEAR 1987—Continued

State	Fiscal year 1987 Foster Care expenditures	IV–B transfer	Fiscal year 1987 average monthly number of children
Michigan	51,865,292		6,933
Minnesota	5,878,608		1,156
Mississippi	1,000,751	686,172	622
Missouri	14,201,755		2,168
Montana	1,745,987		320
Nebraska	3,380,255		879
Nevada	579,175	50,532	320
New Hampshire	1,103,853		1,000
New Jersey	14,412,599		3,364
New Mexico	3,370,434		668
New York	182,946,533	2,677,670	17,445
North Carolina	2,512,635	156,880	1,378
North Dakota	1,181,450		284
Ohio	20,756,093		4,225
Oklahoma	3,888,861		832
Oregon	8,237,335	500,617	1,420
Pennsylvania	50,949,371	1,983,039	7,500
Rhode Island	2,812,959		461
South Carolina	3,239,121		1,040
South Dakota	544,747	155,843	242
Tennessee	1,946,445	981,088	1,045
Texas	13,332,974		2,931
Utah	833,810		299
Vermont	3,643,016		612
Virginia	3,778,382	962,404	1,836
Washington	4,835,178	736,927	1,077
West Virginia	6,865,428		664
Wisconsin	15,808,000		2,746
Wyoming	0		0
Total	690,313,535	11,344,550	112,743

Medicaid Eligibility

Children eligible under the title IV–E foster care program are eligible for Medicaid from the State in which they live. In addition, States have the option under the Federally assisted Medicaid program to provide for Medicaid eligibility for non-IV–E eligible foster care children as a special category of medically needy children.

Voluntary Foster Care Placements

Federal matching funds are available to States for foster care maintenance payments for children placed in foster care under a voluntary placement agreement between the agency and the child's parents. This option was made a permanent provision of law in the 1987 Budget Reconciliation Act. It had been a temporary provision since it was first provided for under the 1980 child welfare legislation (P.L. 96-272). Under the old law, eligibility for Federal foster care funds was limited to those children removed from the home as a result of a judicial determination that continuance in the home would be contrary to the child's welfare. The intent of this voluntary placement provision is to give parents the opportunity to ask for help rather than having a court order the child into care.

A voluntary placement agreement between the agency and the parents must specify, at a minimum, the legal status of the child and the rights and obligations of the parents or guardians, the child, and the agency while the child is in placement. Federal matching for a voluntarily placed foster care child does not continue after 6 months unless there has been a judicial determination that the continued placement is in the best interest of the child. Also, parents have the right to revoke the voluntary placement agreement unless the State agency obtains a judicial determination that the return of the child to the home would be contrary to the child's best interests.

In fiscal year 1986, 22 States claimed Federal matching funds for children in foster care under voluntary placement agreements and involved 1,374 children.

Only if a State has implemented the child welfare and foster care services and procedures requirements of the 1980 legislation (as described beginning on page 571) may that State receive Federal matching funds for children placed under voluntary placement agreements.

Foster Care Funding Ceiling and Transfer of Foster Care Funds to Child Welfare Services—Temporary Provision

Under a provision of law in effect through fiscal year 1989, there is the potential for a State-by-State ceiling on Federal AFDC funding for foster care. This ceiling is intended to create financial incentives to States to implement procedures to reduce unnecessary placement or extended placement in foster care. However, the Federal mandatory ceiling on foster care funds is only in effect when title IV-B child welfare services appropriations is $266 million. This provision was also originally enacted as part of the 1980 child welfare legislation.

A State may use any one of the following methods to calculate the most favorable ceiling: (1) the State's fiscal year 1978 Federal foster care funds increased by 33⅓ percent for fiscal year 1981, and increased thereafter by twice the increase in the CPI each year but not to exceed 10 percent each year; (2) the State's share of $100 million relative to its population under 18; or (3) for those States with foster care caseloads below the national average, the State's funds increased by a percent equal to its caseload growth but not more than 10 percent, plus the increase provided in (1).

However, States may gain flexibility in the use of Federal foster care funds under a voluntary foster care ceiling if they have implemented the child welfare/foster care services and procedures from the 1980 legislation (P.L. 96-272). A portion of the Federal foster care matching funds made available under the ceiling which are not used for foster care maintenance can be used for IV-B child welfare services. In years when the IV-B child welfare services appropriation is insufficient to trigger a mandatory foster care ceiling a State can opt for a voluntary ceiling to gain the option to use foster care funds for child welfare services. The provision in the law which provides States this option expires September 30, 1989, concurrently with the foster care ceiling provision. Under the optional foster care ceiling, States cannot transfer more foster care funds to title IV-B services than an amount which, together with the IV-B funds it receives, exceeds the amount of IV-B funds it would have received if the IV-B appropriation for such year had been sufficient to require a ceiling on foster care funds in all States. Table 1 shows the amount that States transferred in fiscal years 1981 through 1987. Table 2 provides State-by-State data on the transfers for fiscal year 1987 which totaled $11.3 million.

TITLE IV-B CHILD WELFARE SERVICES PROGRAM

Title IV-B of the Social Security Act authorizes funds for the purpose of assisting States in providing services to children and families in need of child welfare services.

States submit a State plan which describes the uses to be made of their allocation under the title IV-B program including a child welfare staff development and training plan. There are no income or AFDC or SSI related eligibility restrictions on the use of title IV-B child welfare services funds.

Funds are allocated to the States according to a formula based on the number of children under the age of 21 and inversely with average per capita income. Federal matching is provided at the rate of 75 percent. The full authorization for the title IV-B program is $266 million. The title IV-B appropriation for fiscal year 1988 is $239.4 million. Table 3 shows the State-by-State allocations of title IV-B funds. States are eligible for their share of any annual appropriation which exceeds $141 million only if they met the requirements in section 427 of the Social Security Act related to the provision of certain services and case plan and case reviews for children in foster care.

TABLE 3.—TITLE IV–B CHILD WELFARE SERVICES STATE-BY-STATE ALLOCATIONS AND STATUS OF STATES COMPLIANCE WITH SECTION 427 CHILD WELFARE PROTECTIONS

[In thousands of dollars]

	Fiscal year—		States compliance with section 427—child welfare protections—fiscal year 1987
	1987 actual	1988 appropriation	
Total	222,500,000	239,350,000	
Alabama	4,782,511	5,000,258	Approved
Alaska	417,461	441,380	Not certified
Arizona	3,343,771	3,591,726	Approved
Arkansas	2,838,108	2,942,450	Approved
California	20,444,523	21,465,358	Approved
Colorado	2,772,353	2,920,963	Approved
Connecticut	2,080,798	2,056,574	Disapproved
Delaware	569,559	631,895	Approved
District of Columbia	385,960	420,777	Approved
Florida	9,104,693	9,634,035	Approved
Georgia	6,621,954	6,876,458	Approved
Hawaii	656,021	1,089,859	Not certified
Idaho	1,304,339	1,370,318	Disapproved
Illinois	9,932,041	10,357,395	Disapproved
Indiana	5,572,204	5,932,270	Approved
Iowa	2,860,739	2,993,107	Approved
Kansas	2,149,780	2,385,985	Approved
Kentucky	4,153,908	4,491,734	Approved
Louisiana	5,105,605	5,645,284	Approved
Maine	1,313,124	1,327,936	Approved
Maryland	3,439,760	3,598,015	Disapproved
Massachusetts	2,713,747	4,237,463	Not certified
Michigan	8,888,274	9,140,331	Approved
Minnesota	3,936,850	4,013,550	Approved
Mississippi	3,519,000	3,865,322	Approved
Missouri	4,958,278	4,999,871	Approved
Montana	977,994	1,026,978	Approved
Nebraska	1,640,992	1,679,814	Approved
Nevada	775,481	880,069	Approved
New Hampshire	950,000	961,347	Disapproved
New Jersey	5,423,704	5,228,047	Approved
New Mexico	1,642,468	1,968,508	Approved
New York	13,529,138	13,687,058	Approved
North Carolina	6,432,173	6,974,615	Approved
North Dakota	749,999	825,173	Approved
Ohio	10,401,850	10,795,082	Approved

TABLE 3.—TITLE IV-B CHILD WELFARE SERVICES STATE-BY-STATE ALLOCATIONS AND STATUS OF STATES COMPLIANCE WITH SECTION 427 CHILD WELFARE PROTECTIONS—Continued

[In thousands of dollars]

	Fiscal year—		States compliance with section 427—child welfare protections—fiscal year 1987
	1987 actual	1988 appropriation	
Oklahoma	3,332,055	3,589,505	Approved
Oregon	2,586,322	2,713,779	Approved
Pennsylvania	10,037,621	10,735,737	Approved
Rhode Island	887,533	907,316	Approved
South Carolina	4,015,235	4,249,515	Approved
South Dakota	853,336	907,318	Approved
Tennessee	5,001,374	5,445,097	Approved
Texas	16,242,739	17,899,275	Approved
Utah	2,554,908	2,710,635	Approved
Vermont	631,801	649,545	Disapproved
Virginia	4,907,459	5,142,674	Approved
Washington	3,774,117	4,127,088	Approved
West Virginia	2,226,496	2,342,809	Disapproved
Wisconsin	4,672,032	4,862,318	Approved
Wyoming	101,228	629,856	Not certified
Guam	303,667	327,549	Approved
Northern Mariana	109,656	114,319	Approved
Puerto Rico	3,671,095	6,242,965	Not certified
Virgin Islands	202,166	295,695	Not certified
Results:			
Approved			33
Disapproved			6
Decision pending			0
Review pending			0
Not certified			5

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[1] Computed as if all States meet section 427 requirements and are eligible for share of amounts above $141 million.

Source: Office of Human Development Services.

SUMMARY OF PROBLEMS IDENTIFIED LEADING TO THE ENACTMENT OF THE 1980 CHILD WELFARE AND FOSTER CARE REFORMS (P.L. 96-272)

During the same time that States were revising their laws and procedures to identify and investigate cases of child abuse and neglect, there was growing evidence that in many cases children were being inappropriately placed or staying too long in foster care. Beginning in the mid-1970's congressional hearings and investigations related to foster care found evidence of the following:

—Placement in foster care without first providing alternative services that might help children remain with their families;
—Placement in foster care that is too restrictive (institutional); too great a distance from their families, and made without regard for their special needs;
—Lack of a written case plan setting out essential elements of the nature and duration of their foster care;
—Lack of periodic reviews of the effectiveness of the case plan in conjunction with a judicial determination of the future status of the child;
—Parents not being apprised of their children's situation and discouragement of parent-child visitation;
—Failure to provide services to help reunite children with their families;
—Imposition of unnecessary barriers to adoption for children unable to return home; and
—Lack of information about the children in foster care, making it difficult to monitor the progress of individual children and to evaluate progress in the entire system.

In identifying some of the problems of specific foster care cases, the nature of the Federal financing role in child welfare and foster care became evident as follows:

—Federal matching funds for foster care maintenance payments under Title IV of the Social Security Act was an open-ended entitlement in contrast to minimal increases in appropriations for funding child welfare services programs to prevent the need for foster care or reunify families.
—Foster care children who were or could be freed for adoption were sometimes not adopted because of the loss of monthly assistance to the foster parents or Medicaid eligibility for the child if the child was adopted.

FEDERAL CHILD WELFARE AND FOSTER CARE SERVICES AND PROCEDURES REQUIREMENTS (P.L. 96–272)

Prior to the enactment of the Adoption Assistance and Child Welfare Amendments of 1980 (P.L. 96–272), the title IV–B child welfare services program was essentially a block grant to States for child welfare related activities including for example, foster care maintenance payments, social work and family counseling, day care and adoption activities. Since 1980, title IV–B funds allocated to a State above the 1979 appropriation level of $56.5 million can only be used for child welfare services.

The 1980 child welfare reform legislation also redefined the purpose of child welfare programs funded under title IV–B as services intended to accomplish the following:

—*Protecting and promoting* the welfare of all children, including handicapped, homeless, dependent or neglected children;
—*Preventing* or remedying, or assisting in the solution of problems which may result in the neglect, abuse, exploitation, or delinquency of children;
—*Preventing* the unnecessary separation of children from their families by identifying family problems, assisting families in resolving their problems and preventing breakup of the family

where the prevention of child removal is desirable and possible;

—*Restoring* to their families children who have been removed, by the provision of services to the child and the families;

—*Placing children in suitable adoptive homes,* in cases where restoration to the biological family is not possible or appropriate; and

—*Assuring adequate care of children away from their homes,* in cases where the child cannot be returned home or placed in adoption.

In Public Law 96-272, a comprehensive set of services, procedures and safeguards are described which are intended to correct the specific problems which had been identified in States child welfare and foster care programs.

The 1980 child welfare reform legislation was enacted in anticipation of significant increases in appropriations for the title IV-B program; i.e., from $56 million to $266 million. The required uses of these additional funds and the requirements related to a State's eligibility to receive such funds are intended as incentives for the implementation of the child welfare reforms.

The title IV-B appropriation for fiscal year 1988 is $239.35 million. As an incentive to States to implement the Public Law 96-272 requirements, title IV-B appropriations in excess of $141 million allocated to a State are available to a State only if an on-site review of the case records and procedures in a State indicates that the reforms have been implemented.

Table 3 provides State-by-State information as to the current status of States' compliance with the services and procedures requirements of title IV-B as specified in section 427 of the law.

In addition, to the title IV-B funding incentives, the eligibility of a State for Federal matching funds for it's title IV-E AFDC foster care program was linked to implementation of certain of the services and procedures reforms.

In summary, these procedures and services include the following:

Foster care information system—A State is to have a statewide information system from which the status, demographic characteristic, location, and the goals for the placement of every child in foster care or who has been in foster care within the preceding 6 months can readily be determined.

Preplacement preventive services.—For a State to be eligible for Federal matching funds for it's title IV-E foster care programs, for each child and prior to placement in foster care, there must be a judicial finding that reasonable efforts have been made to prevent or eliminate the need for the removal of the child from the home. This may include, for example, family counseling, 24-hour crisis intervention services, or the provision of emergency caretakers to provide emergency care in the child's own home instead of removal from the home. When $266 million is appropriated for title IV-B child welfare services for 2 consecutive fiscal years, every State is to have implemented a preplacement preventive service program for all children in foster care in the State.

Case plan and case review system.—Each child receiving foster care that is under the supervision of the State is to have a case plan. The case plan is to be designed to achieve placement in the least restrictive (most family like) setting and in close proximity to the parent's home. The case review system requires that there be an independent administrative review of the case every 6 months to determine the continuing appropriateness of the services, to determine the continuing necessity for placement in foster care, and to project when the child can be returned home, freed for adoption or otherwise permanently placed. There must also be a dispositional hearing within 18 months of the original placement of the child in foster care. This hearing must be held in a family or juvenile court or other court of competent jurisdiction or by an administrative body appointed by a court.

Reunification services program.—States are to have a service program designed to help children, where appropriate, return to their own home or, if that is not possible to achieve another permanent placement, such as adoption or legal guardianship at the earliest possible time.

Independent Living Services for Older Foster Care Children

As indicated in Figure 2, approximately 9 percent of the children who leave foster care in a year do so because they reach the age of majority. Approximately 50,000 foster care youth are 16 years of age and older. From studies of the youth in homeless shelters in New York City it was found that nearly 50 percent had a history of foster care placement. Another New York City study found that within 18 months of leaving foster care, one-third of former foster care girls were receiving AFDC.

The 1985 Budget Reconciliation Act established a new authorized entitlement program to assist States in planning and providing services directed at assisting foster care children age 16 and older in preparing for independent living. The program was authorized for fiscal year 1987 and 1988 but with the provision that States could carry over funds allocated to them for a year to the following year. Allocations to the States are according to the ratio which each State's foster care caseload bore to the national caseload in fiscal year 1984. This determination is to be made on the basis of the average number of children in federally matched foster care. No non-Federal matching funds are required of the States. The authorized entitlement is for $45 million for each year.

The funds are to be used for a variety of services, including: services aimed at enabling participants to complete high school or take part in vocational training; training in daily living skills; budgetting, career planning, etc.; coordination of other services; outreach activities; and the development of individualized plans for the transition to independent living.

Table 4 shows the State-by-State allocation of the $45 million for the program.

The legislation and the information provided to the States by HHS, describes examples of programs and activities which may be funded under the program, including the following:

> *Education and vocational training.*—Enabling participants to seek a high school diploma or its equivalent (GED) or to take part in appropriate vocational training;

Daily living skills.—Provide training in daily living skills, budgeting, locating and maintaining housing, and career planning;

Individual and group counseling.—Provide for individual and group counseling, workshops and conferences on improved self-esteem, and interpersonal and social skills training and development;

Coordination of services.—Efforts to ensure that the older foster child participates in rehabilitation, health, employment, and related programs in the community;

Outreach and community support.—Outreach efforts to ensure participation in independent living programs and development of community organizational efforts and volunteers to provide ongoing support networks for youth leaving foster care;

Transitional independent living plan.—Each youth participating in the program is to have a written transitional independent living plan which is based on an assessment of his needs.

Funds available under the program may be used for special training for agency staff and foster parents to increase their skills in assisting the foster child to learn independent living skills and decisionmaking, planning, and time management.

Table 4 provides State-by-State information as to which of the above listed services a State included in their plan submitted to HHS and which they intended to provide. Table 4 also indicates the States' estimates of the number of foster care children eligible under the program and the number expected to participate.

TABLE 4.—FOSTER CARE INDEPENDENT LIVING PROGRAMS: STATE-BY-STATE ALLOCATIONS; NUMBER OF CHILDREN; TYPES OF SERVICES

State	Educational-vocational training	Daily living skills	Individual and group counseling	Coordination of services	Outreach programs	Transition plan	Other services	Eligible children	Children participating	Federal amount
Alabama	1	1	1	1	1	1	1	180	180	$667,601
Alaska	1	1	1	1	0	1	0	22	10	8,378
Arizona	1	1	1	1	1	1	1	120	120	223,562
Arkansas	1	1	1	1	1	1	0	60	30	174,176
California	1	1	1	1	0	1	1	5,748	5,748	8,023,999
Colorado	1	1	1	1	1	1	0	180	110	530,906
Connecticut	1	1	1	1	1	1	1	268	87	485,047
Delaware	1	1	1	1	1	1	1	26	26	130,522
District of Columbia	1	1	1	1	1	1	1	190	140	701,995
Florida	1	1	1	1	1	1	1	600	600	634,529
Georgia	1	1	1	1	0	1	1	219	197	706,405
Hawaii	0	0	0	0	0	0	1	2	2	11,465
Idaho	1	1	1	1	1	1	1	38	36	68,788
Illinois	1	1	1	1	1	1	1	1,850	1,500	1,810,989
Indiana	1	0	0	1	0	0	1	129	129	655,695
Iowa	1	1	1	1	1	1	1	332	332	289,264
Kansas	1	1	1	1	0	1	1	425	425	461,235
Kentucky	1	1	1	1	1	1	1	598	300	508,858
Louisiana	1	1	1	1	1	1	0	517	413	873,084
Maine	1	1	1	1	1	1	1	200	50	363,785

Maryland	1	1	0	1	0	1	1	423	404	795,918
Massachusetts	1	1	1	1	1	1	1	100	150	408,762
Michigan	1	1	0	0	0	1	1	1,207	900	2,681,869
Minnesota	1	1	1	1	1	1	1	340	340	734,185
Mississippi	1	1	1	1	1	1	1	180	180	330,714
Missouri	1	1	1	1	1	1	0	665	196	832,517
Montana	1	1	1	1	1	1	1	70	50	156,979
Nebraska	1	1	1	1	0	1	1	128	100	280,004
Nevada	1	1	0	1	0	1	0	36	36	98,773
New Hampshire	1	1	1	1	1	1	1	230	230	205,924
New Jersey	1	1	1	1	1	1	0	800	800	1,477,188
New Mexico	1	1	1	0	1	1	1	286	286	133,167
New York	1	1	1	1	1	1	1	2,697	1,618	7,448,116
North Carolina	1	1	1	1	1	1	1	500	500	672,010
North Dakota	1	1	1	1	0	1	0	97	70	123,466
Ohio	1	1	1	1	0	0	1	600	600	1,839,209
Oklahoma	1	1	1	1	1	1	0	118	118	398,620
Oregon	1	1	1	1	0	1	1	221	221	598,371
Pennsylvania	1	1	1	1	1	1	1	1,386	1,386	2,981,716
Rhode Island	1	1	1	1	1	1	1	80	50	202,397
South Carolina	1	1	1	1	1	1	1	100	100	372,604
South Dakota	1	1	1	1	1	1	0	63	40	124,348
Tennessee	1	1	1	0	0	1	1	115	100	500,039
Texas	1	1	1	1	1	1	1	236	200	1,183,955
Utah	1	1	1	1	1	1	1	80	80	130,081

TABLE 4.—FOSTER CARE INDEPENDENT LIVING PROGRAMS: STATE-BY-STATE ALLOCATIONS; NUMBER OF CHILDREN; TYPES OF SERVICES—Continued

State	Educational-vocational training	Daily living skills	Individual and group counseling	Coordination of services	Outreach programs	Transition plan	Other services	Eligible children	Children participating	Federal amount
Vermont	1	1	1	1	1	1	1	64	48	190,050
Virginia	1	1	1	1	1	1	0	324	324	875,289
Washington	1	1	1	1	0	1	1	417	200	530,465
West Virginia	1	1	1	1	1	1	1	215	150	335,123
Wisconsin	1	1	1	1	0	1	1	275	247	999,196
Wyoming	1	1	0	0	0	1	0	42	23	28,662
Total	50	49	45	46	34	48	39	23,799	20,182	45,000,000

Foster Care and Adoption Information System Development

At the present time, there is not in place a child welfare, foster care and adoption information system which mandates States to report information on the numbers, characteristics and status of children and families that come in contact with child welfare and foster care agencies and programs.

Data which are available are largely that collected by the American Public Welfare Association through the Voluntary Cooperative Information System (VCIS) which is financed by a grant from the Department of Health and Human Services. However, because it is a voluntary system, States are not required to adhere to common definitions and are not required to provide all the information requested.

The 1986 Budget Reconciliation Act (P.L. 99-509) included an amendment which mandates certain studies and reports to Congress related to the feasibility of and elements of a system for the collection of data with respect to foster care and adoption in the United States.

The amendment required the Secretary of HHS to establish an Advisory Committee on Adoption and Foster Care Information. On October 1, 1987, the Advisory Committee submitted to the Congress the results of a study which identified the types of data necessary to assess on a continuing basis, the incidence, characteristics and status of adoption and foster care and which is useful for developing appropriate national policies.

Not later than July 1, 1988, the Secretary of HHS is to submit to Congress a report that proposes a method of establishing, administering and financing a system for the collection of data relating to adoption and foster care in the United States including specifying any changes in law that will be necessary. By December 31, 1988, HHS is to promulgate final regulations providing for the implementation of the information system with the full implementation of the system no later than October 1, 1991.

ADOPTION SERVICES AND ASSISTANCE PROGRAMS

"Adoption" means the judicial act of creating the legal relationship of parent and child where it did not exist previously. However, State laws generally require that surrounding the judicial act of adoption that there are legal processes and child welfare services which protect children and the other parties involved.

The adoption of healthy infants still accounts for a high percentage of the children adopted each year. However, since the early 1970's there has been increasing awareness and acceptance of the value of providing permanent adoptive homes for children in foster care or who are in institutional care because of a physical or mental handicap. This led to the enactment of State and Federal laws which have the goal of removing financial and other "barriers" to the adoption of these "children with special needs"; i.e., children who would not otherwise be adopted without special assistance on their behalf to the adoptive parents.

States may use funds from their allocations under the title IV-B child welfare service program and the title XX social services program for adoption services without regard to the AFDC or SSI eligibility of the child. Since October 1, 1980, Federal matching funds under title IV-E have been available to States for the provision of adoption assistance specifically related to encouraging the adoption of "children with special needs".

Number of adoptions.—There are no official Government estimates on the number of children adopted each year in the United States. One estimate by the National Committee for Adoption based on a survey published in 1985, was that there were 50,700 nonrelative adoptions in 1982. That survey also produced the estimate that of those adoptions, 14,000 were of children with "special needs"; and 5,700 were of children from outside the United States.

Based on this same survey, an estimated 19,000 children had adoptions finalized through activities of public adoption agencies during the year ending September 30, 1982.

As described earlier, the 1986 budget reconciliation act established an advisory committee and a timetable intended to lead toward a system for gathering information on adoption.

Adoption procedures, services and assistance.—Activities, services and assistance provided by either public or licensed private nonprofit agencies and which may be among the costs related to the adoption of a child include the following:

—Recruitment of potential adoptive parents;
—Legal and child welfare services related to the termination of birth parents parental rights;
—Home study of prospective adoptive parents by an adoption worker;
—Adoption worker services for "placement for adoption" for a trial period pursuant to State law;
—Monthly adoption assistance payments on behalf of the child to the adoptive parents;
—Health services for the child placed in adoption;
—Adoption worker counseling of the adopting parents family and child and provision of an assessment to the Court of the appropriateness of the adoption placement;
—Legal services and court costs related to the adoption;
—Services related to the filing of an adoption petition by the prospective adoptive parents and a final adoption decree being issued by a Court; and
—Post-adoption counseling, support services and modifications of the adoptive families home related to the needs of a handicapped adopted child.

Title IV-E Adoption Assistance Program

The Adoption Assistance and Child Welfare Amendments of 1980, (P.L. 96-272) authorized a new entitlement program of Federal matching funds for State adoption assistance programs intended to lessen the barriers to the adoption of "children with special needs." States have been required since October 1982 to have an adoption assistance program under title IV-E of the Social Security Act.

Eligibility.—The basic eligibility criteria which determines whether a State can claim Federal matching funds under the title IV-E adoption assistance program is a finding by the State that the child has "special needs" and that because of those needs it is reasonable to conclude that the child could not be adopted unless some form of assistance is provided directly to the child or on behalf of the child to the adoptive parents.

States have considerable latitude in defining "special needs" eligibility criteria and individually determining whether a child is eligible. The title IV–E statute provides that States are to consider such factors and conditions as the following: the child's ethnic background; age; membership in a minority group; physical or mental handicap; or the need to be placed in the same adoptive home as his or her brothers or sisters.

Since January 1, 1987, all "children with special needs" (not just former AFDC, foster care and SSI children) are entitled to some form of adoption asistance under title IV–E. The extension of the title IV–E adoption assistance program to children who are not former AFDC, AFDC foster care or SSI children was an amendment included in the 1986 tax reform legislation (P.L. 99–514). This was in conjunction with the repeal, in the same legislation, of a provision in the Tax Code which allowed for an "adoption expense deduction" for expenses incurred related to the adoption by the taxpayer of a "child with special needs." The deduction was not limited to cases of adoption of children who were former AFDC, AFDC foster care, or SSI children.

As described later, adopted "children with special needs" who are not former AFDC, AFDC foster care or SSI children are not eligible for federally matched monthly adoption assistance payments and are not categorically eligible for Medicaid.

Adoption Assistance Agreements.—A child placed for adoption is entitled to have adoption assistance provided on his or her behalf only as provided for under the provisions of an "adoption assistance agreement" entered into between the State title IV–E adoption agency, the adoptive parents and other relevant agencies, such as, a private adoption agency.

The amount and the nature of the assistance is to take into account the circumstances of the adopting parents and the needs of the child being adopted and may be readjusted periodically with the concurrence of the adopting parents. The amount and the nature of the assistance provided can vary considerably based upon the "barriers" to the adoption of the child which have been identified as part of the finding that the child has "special needs" related to being adopted.

There are four broad categories of adoption assistance and related activities that are eligible for Federal matching funds pursuant to the provisions of the title IV–E program. They are:

—Monthly adoption assistance payments to adoptive parents
—Medicaid eligibility for the child placed for adoption
—Payment (directly or indirectly) of "non-recurring" costs of adoption incurred by the adoptive parents
—Administrative costs, including staff training, related to the adoption assistance program.

Monthly Adoption Assistance Payments.—States have the option to provide adoptive parents of former AFDC, AFDC foster care and SSI children with monthly adoption assistance payments. A primary reason for such payments is to enable foster parents to adopt a "special needs" foster child in their care. The federally matched monthly payments are to be no greater than the foster payment that would have been paid for a particular child and the Federal matching rate is the same as for AFDC foster care payments in a State. Such payments may continue until the child is age 18 or up to age 21 if the child is mentally or physically handicapped.

The 1985 budget reconciliation legislation (P.L. 99-272) eliminated the requirement, effective October 1, 1986, that a monthly adoption assistance payment must be provided on behalf of a "child with special needs." States now have the option to determine whether such an ongoing payment is necessary to assure the adoption of a child.

Medicaid Eligibility as Adoption Assistance.—Children placed in adoption under a title IV-E adoption assistance agreement and who are former AFDC, AFDC foster care or SSI children are categorically eligible for Medicaid as if they were an AFDC recipient.

States also have the option under the Medicaid program to provide Medicaid coverage for other "special needs" children who are adopted if they have been identified as a special category of medically needy children under a State's medicaid program.

Effective October 1, 1986, a child for whom an adoption assistance agreement is in effect is eligible for Medicaid from the State in which they reside irrespective of whether that is the State with whom the adoptive parents have an adoption assistance agreement. This provision was included in the 1985 budget reconciliation legislation.

Adoption Assistance for "Non-recurring Costs of Adoption".—Assistance to adoptive parents with "non-recurring costs of adoption" is now required to be included in any adoption assistance agreement under the title IV-E program. The amount and nature of such assistance is negotiated between the State, the adoptive parents and other agencies included in the agreement.

Prior to January 1, 1987, "non-recurring costs" of adoption were specifically identified as costs not eligible for Federal matching funds under the title IV-E adoption assistance program. States were precluded, for example, from using title IV-E funds to reimburse adoptive parents for legal fees or for adoption fees charged by private non-profit adoption agencies or to indirectly assist adoptive parents by way of contracts with such private agencies. However, adoptive parents could claim as a deduction against their taxable income up to $1,500 of "qualified adoption expenses" related to the adoption of a "child with special needs." "Qualified adoption expenses" were defined in the Tax Code as "reasonable and necessary adoption fees, court costs, attorney fees, and other expenses which are directly related to the legal adoption of a child with special needs."

The 1986 tax reform legislation repealed the adoption expense deduction. However, effective January 1, 1987, the title IV-E program was amended by the same legislation to provide that those same expenses are now adoption assistance program costs for which States can claim 50 percent Federal matching as "non-recurring costs of adoption." The definition of "qualified adoption expenses," formerly in the Tax Code, is now the definition of "non-recurring costs of adoption" under the title IV-E program.

Adoption Assistance Program Administrative and Staff Training Expenses.—States may claim 50 percent Federal matching for administrative expenses related to the provision of adoption assistance under the title IV-E program.

According to a policy announcement by HHS in August 1983, States may claim matching funds for the following activities: recruitment of adoptive homes; placement of the child in the adoptive home; home studies of the prospective adoptive home; case planning; case management; and case review activities.

In addition, administrative costs in the form of training personnel employed or preparing for employment with the agency administering the title IV-E foster care and adoption assistance program are eligible for 75 percent Federal matching.

Table 5 shows the Federal share of the cost of the title IV-E adoption assistance program in fiscal years 1986 and 1987 and the estimated expenditures for fiscal year 1988. The cost of the adoption assistance program has grown from less than $5 million in fiscal year 1982 to an estimated nearly $108 million in fiscal year 1988. An estimated 35,892 children are expected to benefit from the adoption assistance program in fiscal year 1988. Table 5 shows the number of States that have claimed Federal matching funds and the average monthly number of children on whose behalf monthly adoption assistance payments were provided in fiscal years 1981 through 1988.

TABLE 5.—ADOPTION ASSISTANCE STATE CLAIMS FISCAL YEARS 1985–88 AND ESTIMATED AVERAGE NUMBER OF CHILDREN RECEIVING ADOPTION ASSISTANCE FISCAL YEAR 1988

Name of State	Fiscal year—				
	1985 claims	1986 claims	1987 claims	1988 claims (est.)	1988 estimated average monthly number of children
Total	$37,208	$54,518	$71,634	$109,969	35,892
Alabama	123	174	187	287	159
Alaska	0	23	106	163	26
Arizona	512	553	709	1,088	281
Arkansas	131	206	358	550	148
California	5,399	6,919	9,481	14,555	2,766
Colorado	69	222	375	576	243
Connecticut	123	270	513	788	248
Delaware	28	46	69	106	73
District of Columbia	553	411	590	906	241
Florida	1,415	1,708	2,538	3,896	1,051
Georgia	31	94	162	249	139
Hawaii	6	8	18	28	14
Idaho	21	42	70	107	65
Illinois	1,512	1,856	2,667	4,094	1,712
Indiana	251	372	585	898	516
Iowa	166	196	268	411	328
Kansas	132	171	222	341	267
Kentucky	287	441	596	915	368
Louisiana	218	433	711	1,091	576
Maine	220	337	453	695	233
Maryland	375	583	464	712	381
Massachusetts	492	562	823	1,263	439
Michigan	4,117	6,000	8,253	12,669	3,606
Minnesota	454	537	439	674	378
Mississippi	235	290	380	583	307
Missouri	616	955	1,108	1,701	917
Montana	55	73	85	130	19
Nebraska	245	320	366	562	296
Nevada	14	14	14	21	40
New Hampshire	77	31	75	115	65
New Jersey	636	2,742	3,692	5,668	1,274
New Mexico	139	222	348	534	160
New York	13,351	16,462	18,880	28,987	10,435
North Carolina	227	357	504	774	1,078
North Dakota	61	112	108	166	87

TABLE 5.—ADOPTION ASSISTANCE STATE CLAIMS FISCAL YEARS 1985–88 AND ESTIMATED AVERAGE NUMBER OF CHILDREN RECEIVING ADOPTION ASSISTANCE FISCAL YEAR 1988—Continued

Name of State	Fiscal year—				
	1985 claims	1986 claims	1987 claims	1988 claims (est.)	1988 estimated average monthly number of children
Ohio	858	3,418	6,096	9,358	2,237
Oklahoma	88	178	259	398	178
Oregon	56	221	282	433	268
Pennsylvania	669	1,141	1,279	1,963	409
Rhode Island	145	620	910	1,397	308
South Carolina	187	383	549	843	273
South Dakota	34	55	141	216	132
Tennessee	211	316	482	740	230
Texas	872	1,723	1,664	2,554	990
Utah	84	152	266	408	105
Vermont	137	270	272	418	53
Virginia	265	346	589	904	429
Washington	383	453	464	712	553
West Virginia	91	254	241	370	51
Wisconsin	837	1,246	1,923	2,952	740
Wyoming	0	0	0	0	0

Source: Office of Human Development Services.

TABLE 6.—AVERAGE MONTHLY NUMBER OF CHILDREN RECEIVING BENEFITS UNDER TITLE IV–E ADOPTION ASSISTANCE AND FOSTER CARE PROGRAMS, FISCAL YEARS 1981–88

Fiscal year	Number of States participating	Average monthly number of children receiving—	
		Adoption assistance	Foster care
1981	6	165	104,851
1982	23	2,402	97,309
1983	48	5,309	93,360
1984	49	11,581	102,051
1985	49	16,009	108,307
1986	49	22,196	108,193
1987	50	27,294	112,743
1988	50	35,892	NA

Source: Office of Human Development Services.

NA = Not available.

Section 12. Tax Expenditures Related to Retirement, Health, Poverty, Employment, and Disability

INTRODUCTION

A significant portion of the Federal budget consists of direct payments to individuals for retirement, health, public assistance, employment, and disability benefits provided pursuant to entitlement programs. Such programs include: Social Security, veterans' pensions, Medicare, Medicaid, food stamps, Aid to Family with Dependent Children, and Supplemental Security Income.

It is perhaps less well recognized that the Federal government also provides indirect payments to individuals, by means of special income tax deductions, exclusions, and credits related to health and other social policy objectives. These expenditures through the tax system (so-called "tax expenditures") are described in this section.

CONCEPT OF TAX EXPENDITURES

Tax expenditure estimates measure the decreases in individual and corporate income tax liabilities that result from provisions in income tax laws and regulations that provide economic incentives or tax relief to particular kinds of taxpayers. These tax provisions take the form of exclusions, credits, deductions, preferential tax rates, and deferrals of tax liability.[1]

The term "tax expenditure" reflects the assumption that the goals of these favorable tax provisions in many cases could be accomplished by replacing them with direct expenditure programs. Tax expenditures can be viewed as entitlement programs—spending programs that are not subject to the annual appropriations process and that are available as entitlements to eligible individuals and corporations. Tax expenditure provisions, unlike direct spending programs, are administered by the Internal Revenue Service.

The definition of tax expenditures used in this report is consistent with the Congressional Budget Act: i.e., ". . . those revenue losses attributable to provisions of the Federal tax laws which allow a special exclusion, exemption or deduction from gross income or which provide a special credit, a preferential rate of tax or a deferral of tax liability." The legislative history of the Act indicates that tax expenditures are to be defined with reference to a normal income tax structure.[2] The measurement of tax expenditures is discussed at the end of this section.

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[1] Tax expenditure information is provided in annual publications of the Joint Committee on Taxation and in the President's budget. Special Analysis G of the budget contains two tables which estimate the outlay equivalent of, and the revenue loss from, each tax expenditure. The House and Senate Budget Committees publish tax expenditure revenue loss estimates in their reports that accompany budget resolutions reported to their respective houses. The Congressional Budget Office publishes reports on tax expenditures which includes descriptive and analytical material in addition to revenue loss estimates.

TAX EXPENDITURE ESTIMATES

The revenue loss in fiscal year 1989 attributable to tax expenditures related to retirement, health, poverty, employment, and disability is estimated to be $123.9 billion (see Table 1).[3] Tax expenditures related to retirement and health comprise $99.6 billion of this amount, or 80 percent. By comparison, the Congressional Budget Office estimates that outlays for Social Security, veterans' pensions, Medicare, and Medicaid will total $365 billion in 1989, representing over two-thirds of projected outlays for entitlements and other mandatory spending.[4]

Table 1 provides a rough indication of the effect of the Tax Reform Act of 1986 ("1986 Act") on tax expenditures. Tax expenditures related to retirement, health, poverty, employment, and disability increased by only $5.6 billion between fiscal years 1985 and 1989. By comparison, these tax expenditures are estimated to increase by over $47 billion over the 1989-1993 period. The 1986 Act decreased the value of deductions and exclusions from taxable income by reducing the tax bracket of most individuals. The Act further reduced tax expenditures by eliminating 6 million families from the tax rolls. In addition, the 1986 Act decreased certain of the tax expenditures shown in Table 1 by: reducing the exclusion for pension contributions, reducing the deduction for IRA contributions, raising the floor on the itemized deduction for medical expenses (from 5 to 7.5 percent of AGI), and replacing the additional personal exemption for the elderly and blind with an additional standard deduction.

The estimates of tax expenditures in Table 1 are potentially misleading as precise indications of the effect of the Tax Reform Act of 1986 on tax expenditures. Changes in the tax expenditure estimates for 1989 through 1993 shown in the table, compared to the estimates for 1985 in the table, capture more than just the effects of the Tax Reform Act. In some cases, the discrepancies can be significant. Changes in economic assumptions, tax-expenditure estimation methods, and the effects of the Omnibus Budget Reconciliation Act of 1987 are also reflected in the differences between the estimates shown.

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[2] As defined in the Congressional Budget Act, the concept of tax expenditures refers to the corporate and individual income taxes. Federal excise, employment, and estate and gift taxes also have exceptions, exclusions, refunds and credits, which are not included in this section.

[3] Each tax expenditure item is measured without regard to other items. Thus, the addition of various tax expenditure items may be misleading (see discussion of tax expenditure measurement at the end of this section).

[4] CBO, The Economic and Budget Outlook: Fiscal Years 1989-1993, (February 1988) p. 73.

TABLE 1.—TAX EXPENDITURE ESTIMATES: FISCAL YEARS 1985, 1989, 1990, AND 1993 [1]

[Billions of dollars]

Item	1985	1989	1990	1993
Tax Expenditures Related to Retirement:				
Net exclusion of pension contributions and earnings	54.2	45.6	48.2	57.2
Individual retirement plans	9.8	8.0	8.5	10.6
Exclusion of Social Security and railroad retirement benefits:				
Social Security benefits [3]	17.8	18.0	19.1	22.9
Railroad retirement system benefits	0.5	0.4	0.4	0.3
Tax Expenditures Related to Health:				
Exclusions of employer contributions for medical insurance premiums and medical care	20.2	27.6	32.3	45.8
Exclusion of Medicare benefits:				
Medicare Part A	2.5	4.3	4.7	6.3
Medicare Part B	1.3	2.2	2.5	3.5
Deductibility of medical expenses	3.2	2.5	2.7	3.4
Tax Expenditures Related to Poverty:				
Earned income tax credit:				
Nonrefundable portion	0.3	1.2	1.4	1.8
Refundable portion	1.0	5.0	5.4	7.1
Exclusion of public assistance and SSI cash benefits	0.5	0.3	0.3	0.4
Tax Expenditures Related to Employment:				
Dependent care credit	1.9	4.0	4.1	4.6
Exclusion of employer-provided dependent care	0.1	0.2	0.3	0.9
Targeted jobs tax credit	(2)	0.2	0.1	(2)
Tax Expenditures Related to Elderly and Disabled:				
Exclusion of workmens' compensation and special benefits for disabled coal miners:				
Workmen's compensation	2.2	2.9	3.2	4.4
Special benefits for disabled coal miners	0.2	0.2	0.2	0.2
Additional standard deduction for elderly and blind [4]	2.5	1.1	1.2	1.5
Tax credit for elderly and disabled	0.2	0.2	0.2	0.2
Total	118.3	123.9	134.8	171.1

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[1] Tax expenditure estimates for 1989, 1990, and 1993 are based on the tax law enacted through December 31, 1987. Tax expenditure estimates for 1985 (based on the tax law enacted through 1983) are reprinted from: Joint Committee on Taxation, "Estimates of Federal Tax Expenditures for Fiscal Years 1984–1989," (November 9, 1984) JCS–39–84.

[2] Less than $50 million.

[3] Includes disability insurance benefits, OASI benefits for retired workers, and benefits for dependents and survivors.

[4] Includes additional personal exemption which was allowed for elderly and blind taxpayers prior to 1987.

Source: Joint Committee on Taxation.

NET EXCLUSION OF PENSION CONTRIBUTIONS AND EARNINGS

Legislative history

Prior to 1921, no special tax treatment applied to employee retirement trusts. Retirement payments to employees and contributions to pension trusts were deductible by the employer as ordinary and necessary business expenses. Employees were taxed on amounts actually received as well as on employer contributions to a trust if there was a reasonable expectation of benefits accruing from the trust.

Since 1921, in order to stimulate the adoption of retirement plans by employers, the Internal Revenue Code has specifically provided that certain employee trusts are exempt from Federal income tax. The 1921 Code provided an exemption for a trust forming part of a qualified profit-sharing or stock bonus plan. The 1926 Code provided a similar exemption for qualified pension trusts and established deduction limits to limit the extent to which tax-favored treatment would be available under qualified plans. A number of changes to the qualification rules and deduction limits were made prior to the enactment of the 1954 Code.

The special tax treatment afforded employee trusts was retained in the 1954 Code. Section 401(a) (and sections referred to therein) contains the basic qualification standards which the trust must satisfy in order to be exempt from tax under section 501(a); section 404 limits the amount of contributions that can be deducted; and sections 402 and 72 govern the taxation of benefits distributed to employees.

The standards applicable to qualified plans have been revised to reflect Congressional concerns related to the expansion of pension, profit-sharing, and stock bonus plans and the prevention of tax abuses. The rules relating to qualified plans were substantially revised by the Employee Retirement Income Security Act of 1974 ("ERISA"), which added (1) minimum coverage, vesting, benefit accrual, and funding requirements, and (2) overall limits on contributions and benefits. Further revisions of these rules were made by the Tax Reform Act of 1976, the Revenue Act of 1978, the Economic Recovery Tax Act of 1981, the Tax Equity and Fiscal Responsibility Act of 1982, the Deficit Reduction Act of 1984, the Retirement Equity Act of 1984, the Tax Reform Act of 1986, the Consolidated Omnibus Budget Reconciliation Act of 1986, and the Omnibus Budget Reconciliation Act of 1987.

The Tax Reform Act of 1986 made substantial modifications to the limits on deductions for contributions to qualified plans, tax treatment of distributions from such plans, and the qualification rules. These provisions reflect continued Congressional concern that the special tax benefits should only be available if retirement benefits are provided on a nondiscriminatory basis, the benefits are within certain limits, and the benefits are generally used for retirement purposes.

Explanation of provision

Under a plan of deferred compensation that meets the qualification standards of the Internal Revenue Code (a qualified plan), an employer is allowed a deduction for contributions (within the limits of sec. 404) to a tax-exempt trust to provide employee benefits. Similar rules apply to plans funded with annuity contracts. An employer that makes contributions to a qualified plan in excess of the deduction limits is subject to a 10-percent excise tax on such excess (sec. 4972).

The qualification rules for pension, profit-sharing, and stock bonus plans are contained in section 401(a) and sections referred to therein. These rules limit the amount of benefits that can be provided through a qualified plan, and require that benefits be provided on a basis that does not discriminate in favor of highly compensated employees. In addition, qualified plans are required to meet minimum standards relating to coverage (the portion of employees participating in the plan), vesting (the time at which an employee's benefit becomes nonforfeitable), and benefit accrual (the rate at which an employee earns a benefit). Also, minimum funding standards apply to the rate at which employer contributions are required to be made to ensure the solvency of pension plans.

Under sections 402 and 72, an employee who participates in a qualified plan is taxed when the employee receives a distribution from the plan. With certain exceptions, a 10-percent additional income tax is imposed on early distributions from a qualified plan. A 15-percent excise tax is imposed on distributions which exceed a certain amount in any year (sec. 4981A).

If a plan fails to satisfy the qualification requirements, the trust holding plan assets is not tax-exempt, an employer's deduction for plan contributions is allowed when the employee includes the contributions or benefits in income, and benefits generally are includible in an employee's income when they are no longer subject to a substantial risk of forfeiture.

Effect of provision

The exclusion of pension contributions and earnings from tax has encouraged employers to establish retirement plans that meet the qualification requirements of the Code. In addition, the preferential tax treatment of pension trusts may encourage employees to increase their total level of savings. These tax provisions directly benefit only taxpayers who work for employers with qualified plans, and who work for a sufficient period of time to vest in such plans. As is the case with all exclusions, upper income taxpayers with higher marginal tax rates receive more benefit per dollar of pension contribution than lower income taxpayers with lower marginal tax rates.

Pension particpation rises significantly with employee income. Table 2 shows that for younger workers (age 25–34), pension participation rose from 24 percent, for employees with less than $10,000 of earnings, to 71 percent for employees with over $35,000 of earnings in 1983. For older workers (age 45–64), pension participation rose from 34 percent, for employees with less than $10,000 of earnings, to 85 percent for employees with over $35,000 of earnings. Pension participation also rose with employee age, from an average of 51 percent for younger workers to an average of 63 percent for older workers in 1983.

TABLE 2.—PENSION PARTICIPATION OF FULL-TIME EMPLOYEES, BY AGE AND EARNINGS, 1983

Age and earnings class (thousands of dollars)	Thousands of employees	In percent		
		Participating	Not participating	Unknown
All	73,350	54	39	6
Age 25 to 34:				
All	21,976	51	41	7
Under $10	3,878	24	63	13
$10 to $15	5,847	47	45	8
$15 to $20	4,737	60	35	5
$20 to $25	3,770	68	28	4
$25 to $35	2,770	67	29	4
Over $35	975	71	25	4
Age 45 to 64:				
All	19,162	63	30	4
Under $10	3,133	34	59	7
$10 to $15	4,423	57	38	4
$15 to $20	3,632	71	26	3
$20 to $25	3,081	80	18	2
$25 to $35	2,839	82	16	2
Over $35	2,053	85	13	2

Note.—Table excludes those not reporting their earnings.

Source: Congressional Budget Office tabulation from May 1983 Current Population Survey.

Pension participation also varies by industry. Table 3 shows that the highest participation rate occurs among public sector employees. According to 1983 data, 81 percent of public sector employees participate in pensions compared to 47 percent for private sector employees. Employees of regulated public utilities had a participation rate comparable to that of public sector employees. Industries with high participation rates include mining (69 percent) and manufacturing of durable goods (67 percent). Industries with low participation rates include retail (29 percent), construction (32 percent), and miscellaneous services (36 percent). Factors affecting participation rates include firm size, unionization, and job tenure.

TABLE 3.—PENSION PARTICIPATION OF FULL-TIME EMPLOYEES, BY INDUSTRY, 1983

Industry	Thousands of employees	In percent		
		Participating	Not participating	Unknown
All	74,611	54	40	6
Public sector	13,699	81	15	4
Private sector	60,913	47	46	7
Agriculture	1,217	8	83	9
Mining	858	69	28	3
Construction	3,954	32	61	7
Manufacturing:				
Durables	10,759	67	27	6
Nondurables	7,536	59	34	7
Transportation	2,302	53	42	6
Communication and public utilities	2,363	81	16	4
Trade:				
Wholesale	3,812	47	46	7
Retail	9,352	29	63	9
Finance, insurance, and real estate	4,854	54	40	6
Miscellaneous services	13,925	36	57	8

Note.—Table excludes those not reporting their industry.

Source: Congressional Budget Office tabulation from May 1983 Current Population Survey.

INDIVIDUAL RETIREMENT PLANS

Legislative history

The Employee Retirement Income Security Act of 1974 ("ERISA") added section 219 of the Internal Revenue Code, providing a tax deduction for certain contributions to individual retirement arrangements ("IRAs"). Active participants in employer plans were not permitted to make deductible IRA contributions.

In response to concerns that active participants in employer plans often received inadequate retirement benefits, the Economic Recovery Tax Act 1981 ("ERTA") eliminated the provisions restricting IRA eligibility to individuals who were not active participants. In addition, ERTA increased the amount of the deduction.

The Reform Act of 1986 amended section 219 (beginning in 1987) to provide that the full IRA deduction is not available to individuals with income above certain levels who are active participants in an employer-maintained retirement plan. Individuals who are not entitled to the full IRA deduction may make nondeductible contributions to an IRA.

Explanation of provision

An individual is permitted to make deductible IRA contributions up to the lesser of $2,000 ($2,250 for an individual with a nonworking spouse) or 100 percent of compensation (earned income in the case of a self-employed individual) if (1) the individual (or a couple if a joint return is filed) has adjusted gross income ("AGI") that does not exceed an applicable dollar amount, or (2) the individual is not an active participant in an employer plan (or, in the case of certain married individuals, neither the individual nor the individual's spouse is an active participant). The applicable dollar amount is (1) $35,000 in the case of an individual, (2) $50,000 in the case a married couple filing a joint return, and (3) $10,000 in the case of a married individual filing separately. The deduction is phased out over a $10,000 interval, so that the AGI phaseout range is (1) $25,000-$35,000 for individuals, (2) $40,000-$50,000 for married individuals filing jointly, and (3) zero to $10,000 for married individuals filing separately. Individuals are entitled to make nondeductible contributions to the extent deductible contributions are not allowed (as a result of the phaseout).

In the case of an IRA to which either deductible or nondeductible contributions have been made, the investment income of the account is not taxed until withdrawn. Amounts withdrawn from an IRA attributable to deductible IRA contributions, or earnings on deductible or nondeductible IRA contributions, are includible in income, whereas amounts withdrawn from an IRA attributable to nondeductible contributions are treated as a return of basis and, therefore, are not includible in income.

Effect of Provision

The expansion of IRA eligibility following ERTA significantly expanded the use of IRAs. In 1981, 4.1 percent of taxpayers with wage and salary income made IRA contributions. In 1982, the percentage making IRA contributions was 14.5 percent, and by 1985, this figure had grown to 17.8 percent.[5]

As is the case with all exclusions, upper income taxpayers with high marginal tax rates receive more benefit per dollar of IRA contribution than lower income taxpayers with low marginal tax rates. In addition, Table 4 documents that the percentage of participation is greatest among upper income taxpayers. Upper income taxpayers make larger contributions as well. Taxpayers with adjusted gross incomes in excess of $50,000 constituted approximately 29 percent of all IRA contributors, but accounted for more than 35 percent of 1985 IRA contributions.

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[5] CBO, Tax Policy for Pensions and Other Retirement Saving (April 1987), and U.S. Dept. of the Treasury, unpublished Statistics of Income data for 1985.

TABLE 4.—IRA PARTICIPATION BY INCOME CLASS, 1985

Adjusted gross income class	Returns reporting IRA contributions (Number in millions)	(Percent of eligible returns)	Contributions (billions of dollars)
All classes	16.2	17.8	38.2
Under $10,000	0.6	2.3	1.1
$10,000 to 30,000	5.1	13.6	9.7
$30,000 to 50,000	5.7	32.9	13.5
$50,000 to 75,000	3.0	56.5	8.7
$75,000 to 100,000	0.9	74.1	2.7
Over $100,000	0.8	76.1	2.6

Note.—Self employed persons as well as wage and salary employees can contribute to IRAs.

Source: 1985 Statistics of Income.

Congresss created the IRA to permit those workers not covered by private pension plans to reap the benefits of tax-deferred retirement saving, and thereby to build retirement income. Table 5 indicates that despite the existence of IRAs, a substantial number of employees have neither a pension plan nor an IRA.

TABLE 5.—PENSION AND IRA PARTICIPATION BY AGE, 1983

Full-time	Having employees (millions)	Having pension[1] only (percent)	IRA only (percent)	Having both (percent)	Having neither (percent)	Unknown
All employees	74.6	40	5	12	34	7
Ages 25 to 34	22.0	45	4	6	36	7
Ages 45 to 64	19.2	40	9	23	21	4

[1] In this table "pension" does not include Social Security and the employee need not be vested in the pension plan to count as being covered by a pension.

Source: Congressional Budget Office tabulation from May 1983 Current Population Survey of the Bureau of the Census.

Table 5 shows that in 1983, many employees with IRAs also participated in their employer's retirement plan. However, given the substantive changes made by the Tax Reform Act of 1986, Table 5 may not accurately reflect current or future participation experience.

While the data reveal that many taxpayers have established IRAs, some believe that IRAs merely represent funds which taxpayers would have saved in the absence of the tax deduction.[6]

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[6] Galper, Harvey and Charles Bryce, "Individual Retirement Accounts: Facts and Issues," Tax Notes, vol. 31, June 2, 1986, pp. 917-21.

Others argue that funds flowing into IRAs represent money which would not otherwise have been saved.[7]

EXCLUSION OF SOCIAL SECURITY AND RAILROAD RETIREMENT BENEFITS

Legislative history

Social Security benefits.—The exclusion from gross income for Social Security benefits was not initially established by statute. Prior to the Social Security Amendments of 1983, the exclusion was based on a series of administrative rulings issued by the Internal Revenue Service in 1938 and 1941 (see I.T. 3194, 1938-1 C.B. 114, I.T. 3229, 1938-2 C.B. 136, and I.T. 3447, 1941-1 C.B. 191).

A Supreme Court decision in 1937 in which Social Security benefits were characterized as "general welfare" may have been influential in resolving the issue.[8] I.T. 3194 and I.T. 3229 made lump-sum distributions nontaxable; internal IRS memoranda suggested that the payments were considered in the nature of a gift. The reasons underlying I.T. 3447 appear to include the following theories: (1) the benefits are gratuities and, thus, not subject to income tax because gifts are not taxable; (2) the Congress indicated its intent that the benefits not be taxable because it did not specifically make them taxable; and (3) the benefits are in the nature of public assistance for the general welfare and the Congress did not intend to tax with one hand what it pays out with the other.

Under the Social Security Amendments of 1983, a portion of the Social Security benefits paid to higher income taxpayers is included in gross income. In modifying the tax treatment of Social Security benefits in 1983, the Congress stated that Social Security benefits are in the nature of benefits received under other retirement systems, which are subject to taxation to the extent they exceed a worker's nondeductible contributions. The legislative history further indicated that taxing a portion of Social Security benefits improves tax equity by treating more equally all forms of retirement and other income that are designed to replace wages. The tax treatment of Social Security benefits is contained in section 86 of the Internal Revenue Code of 1986.

Railroad retirement benefits.—The exclusion from gross income of benefits paid under the railroad retirement system was enacted in the Railroad Retirement Act of 1935. The rationale for the exclusion was not separately stated, but is presumed to be similar to that for excluding Social Security benefits from gross income.

A portion of the benefits payable under the railroad retirement system (generally, tier 1 benefits) is equivalent to Social Security benefits. The tax treatment of tier 1 railroad retirement benefits was modified in the Social Security Amendments of 1983 to conform generally to the tax treatment of Social Security benefits. Other railroad retirement benefits are taxable in the same manner as employer-provided retirement benefits. The Consolidated Omnibus Budget Reconciliation Act of 1985 provided that tier 1 benefits are taxable in the same manner as Social Security benefits only to the extent that Social Security benefits otherwise would be payable. Other tier 1 benefits are taxable in the same manner as all other railroad retirement benefits.

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[7] Venti, Steven F. and David A. Wise, "The Evidence on IRAs," Tax Notes, vol. 38, January 25, 1988, pp. 411-16.

[8] *Helvering* v. *Davis*, 301 U.S. 619, 640 (1937).

Explanation of provision

Under section 86 of the Internal Revenue Code, a portion of Social Security and tier 1 railroad retirement benefits is included in taxable income for taxpayers whose adjusted gross income ("AGI"), combined with (1) interest on tax-exempt bonds and (2) 50 percent of Social Security and tier 1 railroad retirement benefits, exceeds a base amount. The base amount is $25,000 for unmarried individuals, $32,000 for married couples filing joint returns, and zero for married persons filing separate returns who do not live apart at all times during the taxable year. The amount of benefits includible in income is the lesser of (1) 50 percent of the Social Security and tier 1 railroad retirement benefits, or (2) 50 percent of the excess of the taxpayer's combined income over the base amount.

The portion of tier 1 railroad retirement benefits potentially includible in taxable income under the above formula is the amount of benefits the taxpayer would have received if covered under Social Security. Pursuant to section 72(r) of the Internal Revenue Code of 1986, all other benefits payable under the railroad retirement system are includible in income when received to the extent they exceed employee contributions.

EXCLUSION OF EMPLOYER CONTRIBUTIONS FOR MEDICAL INSURANCE PREMIUMS AND MEDICAL CARE

Legislative history

In 1943, the Internal Revenue Service (IRS) ruled that employer contributions to group health insurance policies did not constitute taxable income to employees. Employer contributions to individual health insurance policies, however, were declared to be taxable income in an IRS revenue ruling in 1953.

Section 106 of the Internal Revenue Code, enacted in 1954, reversed the 1953 IRS ruling. As a result, employer contributions to all health and accident plans generally are excluded from taxable income. The legislative history of section 106 indicates that its purpose is to make uniform the tax treatment of employer contributions to group and individual health plans. In addition, under section 105 of the Internal Revenue Code, benefits received under an employer's health plan generally are not included in the employee's income.

In the Revenue Act of 1978, Congress added section 105(h) to tax the benefits payable to highly compensated employees under a self-insured medical reimbursement plan if the plan discriminated in favor of the highly compensated employees. The Tax Reform Act of 1986 modified the health provisions by repealing section 105(h), amending section 106 to exclude employer-provided coverage (rather than contributions) under an accident or health plan, and providing that the exclusion under section 106 does not apply to highly compensated employees under an employer-provided health plan (whether or not self insured) unless the plan does not discriminate in favor of the employer's highly compensated employees. In enacting these limitations on the exclusion for employer-provided health coverage, Congress stated its intent that the exclusion should not be available if a health plan favors the highly compensated employees of an employer.

Explanation of provision

Under section 106 of the Internal Revenue Code of 1986, gross income of an employee generally does not include employer-provided coverage under an accident or health plan.

Section 105 of the Code provides that gross income does not include amounts received by an employee for personal injuries or sickness if the amounts are paid directly or indirectly to reimburse the employee for expenses incurred for medical care.

Section 89 of the Code provides that, in the case of a discriminatory employee benefit plan (including a health plan), a highly compensated employee is required to include in income all or a portion of the employee's employer-provided benefit. The employee's employer-provided benefit generally is the value of the coverage provided to an employee under a health plan, rather than the amount of benefits actually paid directly or indirectly to the employee for medical care.

The exclusion under section 106 for employer-provided health coverage generally does not apply to an employer's highly compensated employees if any group health plan maintained by the employer fails to satisfy the health care continuation rules of section 162(k).

Effect of provision

Historically, the tax law has included incentives for employers to provide certain benefits to their employees, such as health coverage. Nondiscrimination requirements have been imposed to assure that such programs benefit, in addition to highly compensated employees, significant numbers of lower paid employees.

The exclusion for employer-provided health coverage provides an incentive for compensation to be furnished in the form of health coverage, rather than in cash subject to current taxation. As is the case with any deduction or exclusion, this incentive is largest for employees subject to tax at the highest marginal tax rate.

Table 6 presents data summarizing the growth over four decades of employer contributions to group health plans.[9] Contributions to group health plans, second only to qualified pension plans in dollar amount, more than doubled in the five year period 1980–1985, and reached $108.0 billion in 1986.

Table 6 also shows the rate at which group health benefits have grown compared to total wages and salaries. Group health benefits grew from 0.8 percent of wages in 1955 to 5.2 percent of wages in 1986.

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[9] The data includes employer contributions for disability insurance which accounts for roughly 10 percent of total contributions.

TABLE 6.—EMPLOYER CONTRIBUTIONS FOR GROUP HEALTH INSURANCE, 1955–1986

[Dollar amounts in billions]

	1955	1960	1965	1970	1975	1980	1985	1986
Amount [1]	$1.7	$3.4	$5.9	$12.1	$24.0	$49.8	$101.6	$108.0
Percent of wages	0.8	1.2	1.6	2.2	3.0	3.7	5.1	5.2

[1] Amounts are based on Department of Commerce reported data and include employer contributions for short- and long-term disability insurance covering private employees and their dependents.

Table 7 compares the increase in wages to the increase in health benefits during the 1950–1986 period. Between 1950 and 1955, health benefit contributions increased 1.5 cents for every dollar increase in aggregate wages. During the 1970's, health benefit contributions increased approximately 4.7 cents for each dollar increase in wages. Over the 1980 to 1985 period, health benefit contributions accelerated to 8.4 cents of each dollar of wage growth, while slowing down in 1986 to 5.6 cents of each dollar of wage growth.

TABLE 7.—INCREASE IN EMPLOYER GROUP HEALTH INSURANCE CONTRIBUTIONS PER DOLLAR OF WAGE INCREASE, 1950–86

Years:	Cents
1950–55	1.5
1955–60	2.8
1960–65	2.8
1965–70	3.3
1970–75	4.6
1975–80	4.7
1980–85	8.4
1986	5.6

Source: Computed from U.S. Department of Commerce data.

EXCLUSION OF MEDICARE BENEFITS

Legislative history

The exclusion from income of benefits under Part A of Medicare has never been expressly established by statute. A 1970 IRS ruling, Rev. Rul. 70–341, 1970–2 C.B. 31, provided that the Part A benefits are not includible in gross income because they are in the nature of disbursements made in furtherance of the social welfare objectives of the Federal Government. The Internal Revenue Service relied for this holding on a similar ruling, Rev. Rul. 70–217, 1970–1 C.B. 12, with respect to old age and survivors insurance benefits and disability insurance benefits ("OASDI"). (For background on the exclusion of OASDI benefits, see above.)

Rev. Rul. 70–341 held that benefits under Part B of Medicare are excludable under section 104 as insurance proceeds (though the subsidized portion of Part B also may be excluded on the same grounds applicable to Part A).

Explanation of provision

Benefits under Part A and Part B of Medicare are excludable from the gross income of the recipient. In general, Part A pays for certain inpatient hospital care, skilled nursing facility care, home health care, and hospice care for eligible individuals (generally the elderly and the disabled). Part B covers certain doctor's services and other medical services for elderly or disabled individuals who elect to pay the required premium.

DEDUCTIBILITY OF MEDICAL EXPENSES

Legislative history

An itemized deduction for unreimbursed medical expenses above a specified floor has been allowed since 1942. From 1954 through 1982, the floor under the medical expense deduction was 3 percent of the taxpayer's adjusted gross income ("AGI"); a separate floor of 1 percent of AGI applied to expenditures for medicine and drugs.

In the Tax Equity and Fiscal Responsibility Act of 1982, the overall floor was increased to 5 percent of AGI, and was applied to the total of all eligible medical expenses, including prescription drugs and insulin. The 1982 Act made nonprescription drugs ineligible for the deduction, and eliminated the separate floor for drug costs.

The Tax Reform Act of 1986 increased the floor under the medical expense deduction to 7.5 percent of AGI, beginning in 1987.

Explanation of provision

Individuals who itemize deductions may deduct amounts paid during the taxable year, if not reimbursed by insurance or otherwise, for medical care of the taxpayer and of the taxpayer's spouse and dependents, to the extent that the total of such expenses exceeds 7.5 percent of adjusted gross income (sec. 213).

Medical care expenses eligible for the deduction include amounts paid by the taxpayer for (1) health insurance (including after-tax employee contributions to employer health plans and Medicare premiums); (2) diagnosis, treatment, or prevention of disease or malfunction of the body; (3) transportation primarily for and essential to medical care; and (4) lodging away from home primarily for and essential to medical care, up to $50 per night. The costs of prescription drugs and insulin also are eligible for the medical care expense deduction.

Expenses paid for the general improvement of health, such as fees for exercise or weight-reduction programs, are not eligible for the deduction unless prescribed by a physician to treat a specific illness or physical defect.

Effect of provision

Under general tax principles, personal expenses such as medical expenses are not deductible from gross income. However, the Code permits an itemized deduction where unreimbursed medical expenses absorb a substantial portion of income, and thus adversely affect the taxpayer's ability to pay taxes. In order to limit the deduction to extraordinary expenses, the tax law provides that medical expenses are deductible only to the extent that they exceed a specified percentage (now 7.5 percent) of the taxpayer's AGI.

The deduction is not limited to expenses of specifically defined diseases or to types of expenditures deemed to be involuntary. Thus, voluntary medical expenses, e.g., some types of cosmetic surgery, may be eligible for the deduction.

Of the tax returns on which the deduction is claimed, 67 percent represent taxpayers below the $40,000 income class. As Table 8 shows, these returns (below the $40,000 income class) obtain 37 percent of the tax benefits provided by the medical expense deduction.

TABLE 8.—DISTRIBUTION OF TAX EXPENDITURE: MEDICAL DEDUCTION, 1989

Income class (thousands)	Returns (thousands)	Amount (millions)
Below $10	71	7
$10 to $20	767	170
$20 to $30	1,264	344
$30 to $40	1,323	421
$40 to $50	795	407
$50 to $75	651	432
$75 to $100	155	240
$100 to $200	82	338
$200 and Over	17	172
Total	5,125	2,541

EARNED INCOME TAX CREDIT

Legislative history

The earned income tax credit (Code sec. 32) was enacted in 1975 as a means of targeting tax relief to working low-income taxpayers with children, providing relief from the Social Security payroll tax for these taxpayers, and improving incentives to work.

As originally enacted, the credit equaled 10 percent of the first $4,000 of earned income (i.e., a maximum credit of $400). The credit began to be phased out for adjusted gross income ("AGI") (or, if greater, earned income) above $4,000, and was entirely phased out for taxpayers with AGI of $8,000. For 1979 through 1984, the maximum credit was increased to $500 (10 percent of the first $5,000 of earned income). Also, the income level at which the phaseout began was raised to $6,000, with a complete phaseout not occurring until an income level of $10,000. For 1985 and 1986, the credit was increased to 11 percent of the first $5,000 of earned income. The maximum credit of $550 was reduced for income in excess of $6,500, and was completely phased out for income equal to or in excess of $11,000. Prior to 1987, the dollar amount of the earned income credit was not indexed for inflation.

Under the Tax Reform Act of 1986, the credit was increased to 14 percent of the first $5,714 of earned income, beginning in 1987. The maximum amount of the credit ($800) is reduced by 10 cents for each dollar of AGI (or, if greater, earned income) in excess of $6,500 ($9,000 after 1987), and the credit is completely phased out at an income of $13,500 ($17,000 after 1987). These amounts are before adjustment for inflation occurring after fiscal year 1984 (see discussion below).

Explanation of provision

Eligibility.—The earned income credit is available to married individuals filing joint returns who are entitled to a dependency exemption for a child; surviving spouses (who, by definition, must maintain a household for a dependent child); and unmarried heads of households who maintain a household for a child. A dependency exemption generally is available only if the taxpayer provides more than half the total support of the child, and a taxpayer is considered to maintain a household only if more than half the household expenses are furnished by that individual. For this purpose, benefits under the AFDC program (Aid to Families with Dependent Children) are not considered as support provided or furnished by the taxpayer. Thus, if more than half of an individual's or couple's income is from AFDC or another source other than their own income or resources, the earned income credit generally is not available.

Benefits.—Beginning in 1987, the credit equals 14 percent of the first $5,714 of earnings, including net earnings from self-employment plus an adjustment for inflation ($6,080 after inflation adjustment in 1987).[10] The size of the credit is unrelated to the number of dependents (in excess of one). For each dollar of adjusted gross income (or, if higher, earned income) above $6,500 ($6,920 after inflation adjustment in 1987), the maximum credit ($851 in 1987) is reduced by 10 cents. The income phaseout starting point is raised to $9,000 after 1987.

Unlike most tax credits, the earned income credit is refundable; i.e., if the amount of the credit exceeds the taxpayer's Federal income tax liability, the excess is payable to the taxpayer. Also, under an advance payment system, eligible taxpayers may elect to receive the benefit of the credit in their paychecks, rather than waiting to claim a refund on their return filed by April 15 of the following year.

Interaction With AFDC and food stamps.—The treatment of the earned income tax credit for purposes of AFDC and food stamp benefit computations has varied since inception of the credit. When earned in 1975, the credit was not considered income in determining AFDC and food stamp benefits, and the credit could not be received on an advance basis. From January 1979 through September 1981, the credit was treated as earned income when actually received. Receipt of the credit on an advance basis was authorized in July 1979.

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[10] Under the Tax Reform Act of 1986, the income base eligible for credit and the phaseout starting point are adjusted for inflation occurring after August 31, 1984. Thus, for example, the maximum amount of earned income eligible for the credit beginning in 1987 equals $5,714 as adjusted for inflation between August 31, 1984 and August 31, 1986. Any inflation adjustment relating to the credit that is not a multiple of $10 is rounded to the nearest multiple of $10.

From October 1981 to September 1984, the amount of the credit was treated as earned income and was imputed to the family even though it may have not been received as an advance payment. Pursuant to the Deficit Reduction Act of 1984, the credit is treated as earned income only when it is received, either as an advance payment or as a refund after conclusion of the year.

Under Federal rules, a State generally has the option of treating a tax refund as either unearned income in the month of receipt, or as a resource. However, the amount of earned income credit embodied within a tax refund is treated as earned income in the month the refund is received. If the refund is treated as unearned income, it reduces the amount of the AFDC benefit on a dollar-for-dollar basis.

Food stamp rules do not have a similar requirement. In determining the food stamp benefit, the credit is counted as earned income for the month of receipt, if received on an advance basis, or as an asset, if received in a lump sum at the end of the year.

Effect of provision

For calendar year 1986, earned income tax credits totaled $2.0 billion, of which about $1.5 billion represented Treasury payments in excess of current year tax liability and $0.5 billion was offset against the individual's tax liability (see Table 9). Some 6.3 million families received the credit, which averaged $321 per family. Of total recipients, over 4.6 million received a portion of the earned income tax credit in the form of Treasury payment (rather than a reduction in tax liability). Only approximately 10,000 families received advance payments, totaling about $2.2 million in 1986.

Table 9 shows the total amount of earned income credits received for each of the calendar years since the inception of the program, the number of recipient families, the amount of the credits received as Treasury payments, and the average amount of the credit received per family.

TABLE 9.—TOTAL AMOUNT OF EARNED INCOME CREDIT, NUMBER OF FAMILIES RECEIVING CREDIT, AND BUDGET OUTLAYS, 1975–90

Calendar year to which credit applies	Total amount of credit (millions)	Number of families who received credit (thousands)	"Refunded" portion of credit [1] (millions)	Average credit per family
1975	$1,250	6,215	$900	$201
1976	1,295	6,473	890	200
1977	1,127	5,627	880	200
1978	1,048	5,192	801	202
1979	2,052	7,135	1,395	288
1980	1,986	6,954	1,370	286
1981	1,912	6,717	1,278	285
1982	1,775	6,395	1,222	278
1983	1,786	6,250	1,287	286
1984	1,636	6,376	1,162	257
1985	2,096	6,515	1,506	322

TABLE 9.—TOTAL AMOUNT OF EARNED INCOME CREDIT, NUMBER OF FAMILIES RECEIVING CREDIT, AND BUDGET OUTLAYS, 1975–90—Continued

Calendar year to which credit applies	Total amount of credit (millions)	Number of families who received credit (thousands)	"Refunded" portion of credit [1] (millions)	Average credit per family
1986 [2]	2,016	6,287	1,488	321
1987 [3]	4,067	8,123	3,341	501
1988 [3]	6,145	11,594	4,881	530
1989 [3]	6,725	12,141	5,379	554
1990 [3]	7,457	13,797	5,915	540

[1] This is the portion of the credit that exceeds tax liability, and it is treated as a budget outlay. The rest of the credit is classified as a "tax expenditure." All these credits were paid in the following year until 1979, when advance payments of the credit were permitted by addition to the worker's paycheck.

[2] Preliminary.

[3] Projection.

The income limitations for the earned income credit are indexed for inflation. Table 10 shows the amount of credit available at various income levels in 1987, and projections for 1988 and 1989 based on Congressional Budget Office estimates of inflation.

TABLE 10.—EARNED INCOME CREDIT SCHEDULE, 1987–89

Adjusted gross income [1]	Earned income credit		
	1987	1988	1989 [2]
$1,000	$142	$140	$142
2,000	282	280	282
3,000	422	420	422
4,000	562	560	562
5,000	702	700	702
6,000	842	840	842
6,080	[3] 851	851	853
6,240	851	[3] 874	876
6,520	851	874	[3] 913
7,000	842	874	913
8,000	742	874	913
9,000	642	874	913
10,000	542	858	913
11,000	442	758	839
12,000	342	658	739
13,000	242	558	639
14,000	142	458	539
15,000	42	358	439
15,432	[4] 0	315	395
16,000	0	258	339
17,000	0	158	239
18,000	0	58	139
18,580	0	[4] 0	81

TABLE 10.—EARNED INCOME CREDIT SCHEDULE, 1987–89—Continued

Adjusted gross income [1]	Earned income credit		
	1987	1988	1989 [2]
19,000	0	0	39
19,398	0	0	[4] 0

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[1] Adjusted gross income is assumed equal to earned income (i.e., wages, salaries, tips, nontaxable compensation, and self-employment income).

[2] Estimated based on the Consumer Price Index forecast of the Congressional Budget Office.

[3] Maximum earned income credit.

[4] Earned income credit fully phased out.

TABLE 11.—DISTRIBUTION OF TAX EXPENDITURE: EARNED INCOME CREDIT, 1989

Income class (thousands)	Returns (thousands)	Amount (millions)
$0 to $10	2,870	$2,077
10 to 20	7,697	4,065
20 to 30	7,314	456
30 to 40	177	75
40 to 50	43	22
50 to 75	7	5
75 to 100		
100 to 200		
200 and over		
Total	12,109	$6,700

EXCLUSION OF PUBLIC ASSISTANCE AND SSI BENEFITS

Legislative history

While there is no specific statutory authorization, a number of revenue rulings under Code section 61 have held specific types of public assistance payments are excludable from gross income. Revenue rulings generally exclude government transfer payments from income because they are considered to be general welfare payments. While no specific rationale has been advanced for this exclusion, the reasoning may be similar to that for the original exclusion of Social Security benefit payments—that they are in the nature of gifts and that the Congress did not intend to tax with one hand what it pays out with the other. Also, taxing benefits provided in kind, rather than in cash (e.g., Medicaid) would require valuation of these benefits, which would create administrative difficulties.

Explanation of provision

The Federal Government provides public assistance benefits tax free to individuals either in the form of cash payments or by providing certain goods and services free of charge. Cash payments come mainly from the Aid to Families with Dependent Children ("AFDC") and Supplemental Security Income ("SSI") programs. In-kind payments include food stamps, Medicaid, and housing assistance.

DEPENDENT CARE CREDIT

Legislative history

Under section 21 of the Internal Revenue Code, a tax credit is allowed with respect to certain employment-related expenses for dependent care. The origin of the credit was a provision enacted in section 214 of the Internal Revenue Code of 1954, providing a deduction to gainfully employed women, widowers, and legally separated or divorced men for certain employment-related dependent care expenses. The deduction was limited to $600 per year and was phased out for families with income between $4,500 and $5,100. The intent of the provision was to recognize that, while having personal consumption characteristics, certain dependent care expenses are sufficiently similar to employee business expenses to justify a limited tax benefit.

The Revenue Act of 1964 made husbands with incapacitated wives eligible for the dependent care deduction and raised the threshold for the income phaseout from $4,500 to $6,000.

The Revenue Act of 1971 made any individual maintaining a household eligible for the deduction (subject to a gainful employment requirement). The 1971 Act also (1) modified the definition of a dependent, (2) raised the deduction limit to $4,800 per year, (3) increased from $6,000 to $18,000 the income level at which the deduction began to be phased out, (4) allowed the deduction for household services in addition to direct dependent care, and (5) limited the deduction with respect to services outside the taxpayer's household. The 1971 amendment was intended to encourage the hiring of domestic workers, encourage the care of incapacitated persons at home rather than in institutions, and provide relief to middle- and low-income taxpayers.

The Tax Reduction Act of 1975 increased from $18,000 to $35,000 the income level at which the deduction began to be phased out.

The Tax Reform Act of 1976 replaced the deduction with a nonrefundable credit. Congress believed that (1) the benefits of this provision should not be limited to taxpayers who itemize deductions, (2) a tax credit would provide relatively more benefit than a deduction to taxpayers in the lower tax brackets, (3) the prior rules governing married couples, divorced and separated persons, and payments to relatives were unduly restrictive, and (4) computation of the deduction was too complex.

The Revenue Act of 1978 further modified the rules relating to whether payments to relatives qualify as creditable expenses. In the Economic Recovery Tax Act of 1981, Congress provided (1) a higher ceiling on creditable expenses, (2) a larger credit for lower income individuals, and (3) modified rules relating to care provided outside the home. In the Omnibus Budget Reconciliation Act of 1987, the credit was amended to make expenses incurred for an overnight camp ineligible for the credit.

Explanation of provision

A nonrefundable credit against income tax liability is available for up to 30 percent of a limited amount of employment-related dependent care expenses. Eligible employment-related expenses are limited to $2,400 if there is one qualifying individual, and $4,800 if there are two or more qualifying individuals. The credit may be claimed by an individual who maintains a household that includes one or more qualifying individuals. Generally, a qualifying individual is a dependent under the age of 15, a physically or mentally incapacitated dependent, or a physically or mentally incapacitated spouse.

Employment-related dependent care expenses are expenses for the care of a qualifying individual incurred to enable the taxpayer to be gainfully employed, other than expenses incurred for an overnight camp. For example, amounts paid for the services of a housekeeper generally qualify if such services are performed at least partly for the benefit of a qualifying individual; amounts paid for a chauffeur or gardener do not qualify.

The amount of employment-related expenses that may be taken into account in computing the credit generally may not exceed an individual's earned income or, in the case of married taxpayers, the earned income of the spouse with the lesser earnings. (This limitation does not apply in the case of a spouse who is a full-time student or who is incapable of caring for himself or herself.) Thus, if one spouse is not working, no credit generally is allowed.

The 30-percent credit rate is reduced, but not below 20 percent, by one percentage point for each $2,000 (or fraction thereof) of adjusted gross income ("AGI") above $10,000. Because married couples are required to file a joint return to claim the credit, a married couple's combined AGI is used for purposes of this computation.

Effect of provision

From 1976 to 1986, utilization of the dependent care credit increased from 2.7 to 9.3 million families, the amount of credits claimed increased from $0.5 billion to $3.5 billion, and the average amount of credit claimed per family increased from $206 to $379 (see Table 12).

TABLE 12.—DEPENDENT CARE CREDIT, 1976–90

Calendar year	Returns claiming dependent credit (thousands)	Amount of credit claimed (dollars in millions)	Average credit per return (dollars)
1976	2,660	$548	$206
1977	2,910	521	179
1978	3,431	654	191
1979	3,833	793	207
1980	4,231	956	226
1981	4,578	1,148	251

TABLE 12.—DEPENDENT CARE CREDIT, 1976–90—Continued

Calendar year	Returns claiming dependent credit (thousands)	Amount of credit claimed (dollars in millions)	Average credit per return (dollars)
1982	5,004	1,501	300
1983	6,367	2,051	322
1984	7,546	2,649	351
1985	8,417	3,127	372
1986 [1]	9,228	3,494	379
1987 [2]	9,413	3,829	407
1988 [2]	9,601	4,024	419
1989 [2]	9,701	4,103	423
1990 [2]	9,860	4,386	445

[1] Preliminary.

[2] Estimated.

The bulk of the dependent care credit is claimed by families filing joint returns. In 1985, approximately two-thirds of the $3.1 billion of credits were claimed on joint returns and one-third on head of household returns (see Table 13). (A negligible amount of dependent care credit is claimed on single returns by custodial parents who are not eligible to claim dependent exemptions.)

In 1985, 64 percent of the dependent care credits claimed on joint returns were attributable to returns with less than $40,000 in adjusted gross income ("AGI"). By comparison, over 75 percent of the credit claimed on head of household returns was attributable to returns with less than $20,000 in AGI. The difference reflects the fact that two-earner households, on average, have higher incomes than single-earner households.

TABLE 13.—DISTRIBUTION OF DEPENDENT CARE CREDIT BY FILING STATUS, 1985

[Dollar amounts in millions except AGI class]

AGI class of tax return (thousands)	Joint returns		Head of household		Single returns [1]	
	Amount	Percent	Amount	Percent	Amount	Percent
$0 to $10	$12.2	0.6	$165.1	15.5	$3.7	9.7
$10 to $20	282.8	14.0	641.2	60.1	28.3	74.3
$20 to $30	504.7	25.0	193.1	18.1	3.6	9.4
$30 to $40	492.1	24.3	51.3	4.8	1.0	2.8
$40 to $50	365.4	18.1	10.1	0.9	1.0	2.8
$50 to $75	289.2	14.3	3.5	0.3	0.3	0.9
$75 to $100	43.0	2.1	1.8	0.2	0.0	0.1
$100 to $200	28.4	1.4	0.8	0.1	0.0	0.0
$200 and up	4.8	0.2	0.2	0.0	0.0	0.0
Total	2,022.6	100.0	1,067.0	100.0	38.1	100.0

[1] A very small amount of the dependent care credit is claimed on single returns by certain custodial parents who are not eligible to claim dependent exemptions.

The average dependent care credit claimed on joint returns in 1985 was $342, over $100 less than the average $445 claimed on head of household returns (see Table 14).

TABLE 14.—PERCENT CLAIMING DEPENDENT CARE CREDIT AND AVERAGE AMOUNT CLAIMED, 1985

AGI class of tax return (thousands)	Joint returns		Head of households	
	Average amount claimed (dollars)	Percent claiming credit	Average amount claimed (dollars)	Percent claiming credit
$0 to $10	$157	1.2	$260	15.7
$10 to 20	303	9.4	523	33.0
$20 to $30	328	15.3	507	25.0
$30 to $40	336	16.1	458	18.1
$40 to $50	368	16.9	376	19.8
$50 to $75	398	14.3	330	11.1
$75 to $100	391	9.6	347	25.3
$100 to $200	478	7.4	427	9.6
$200 and up	517	3.7	698	5.3
Average	342	12.2	445	23.6

Only 16 percent of head of household returns with AGI less than $10,000 claimed in the dependent care credit in 1985, compared to 33 percent for head of household returns with AGI between $10,000 and $20,000. A Bureau of Census study[11] of child care arrangements used by mothers for their youngest child under age five may provide some explanation. For those with family income under $15,000, only about 36 percent used child care arrangements for which cash payments are most common—care in a home by a nonrelative or care in a nursery school or day care center. The remainder used care by relatives (other than the 5 percent not classified or reported).

EXCLUSION FOR EMPLOYER-PROVIDED DEPENDENT CARE

Legislative history

The Economic Recovery Tax Act of 1981 added section 129 of the Internal Revenue Code, under which certain employer-provided dependent care is excluded from the employee's gross income. The 1981 Act also amended Code section 3121(a)(18) and section 3306(b)(13) to exclude such employer-provided dependent care from wages for purposes of the Federal Insurance Contributions Act ("FICA") and the Federal Unemployment Tax Act ("FUTA"). Certain technical amendments were made to section 129 in the Technical Corrections Act of 1982 and in the Deficit Reduction Act of 1984. The Tax Reform Act of 1986 further amended Code section 129 by modifying the nondiscrimination rules and by limiting the exclusion of $5,000 in a year ($2,500 in the case of a separate return by a married individual).

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[11] U.S. Department of Commerce, Bureau of the Census, "Child Care Arrangements of Working Mothers: June 1982" (Series P23, No. 129), 1983.

The dependent care exclusion is intended to provide an incentive for employers to provide dependent care benefits to their employees.

Explanation of provision

Amounts paid or incurred by an employer for dependent care assistance provided to an employee generally are excluded from the employee's gross income if the assistance is furnished under a program meeting certain requirements. These include requirements that the program is in writing and satisfy certain nondiscrimination rules, and that reasonable notification of the program is provided to eligible employees.

With respect to any taxpayer (including a married couple filing a joint return), the dependent care exclusion is limited to $5,000 in a year ($2,500 in the case of a separate return by a married individual). Amounts excluded from gross income generally are excludable from wages for purposes of FICA and FUTA.

Effect of provision

The exclusion provides an incentive for compensation to be furnished in the form of dependent care assistance, rather than in cash subject to taxation. As is the case with any deduction or exclusion, this incentive is of greater value to employees in higher tax brackets.

Many employees covered by the exclusion for employer-provided dependent care also are eligible to use the dependent care tax credit. Thus, the exclusion may either substitute for, or supplement, the dependent care credit. While the rules and limitations differ between the exclusion and the credit for dependent care expenses, the credit generally is less valuable than the exclusion for taxpayers who are above the 15-percent tax bracket.

TARGETED JOBS TAX CREDIT

Legislative history

Congress enacted the targeted jobs tax credit (sec. 51 of the Internal Revenue Code) in the Revenue Act of 1978 to replace an expiring credit for increased employment. The targeted jobs credit is intended to provide an incentive for hiring specific, targeted groups of individuals. The groups eligible for the credit consist of individuals who are (1) recipients of payments under means-tested transfer programs, (2) economically disadvantaged (as measured by family income), or (3) disabled.

As initially enacted, the targeted jobs credit was allowed for qualified wages paid before 1982. The Economic Recovery Tax Act of 1981 ("ERTA") extended the availability of the targeted jobs credit to qualified wages paid to individuals beginning work for the employer before 1983. Under ERTA, the employer could claim the credit for qualified wages paid to such individuals for services rendered in 1983 and 1984. The Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA") extended the availability of the credit to qualified wages attributable to services performed in 1985 and 1986, paid to individuals who began work for the taxpayer before 1985. The Deficit Reduction Act of 1984 ("the 1984 Act") extended the availability of the credit to qualified wages attributable to services performed in 1986 and 1987, paid to individuals who began work for the taxpayer before 1986. The Tax Reform Act of 1986 ("the 1986 Act") extended the availability of the credit to qualified wages attributable to services performed in 1988 and 1989, paid to individuals who began work for the taxpayer before 1989. The credit expires for individuals hired after 1988.

In addition, ERTA, TEFRA, and the 1984 Act altered the targeted group definitions and made several administrative and technical changes in the credit provisions. The 1986 Act generally reduced the maximum credit per year, limited to one year the period per employee for which the credit may be claimed, established a minimum employment period for credit eligibility, and extended the authorization for appropriations for administrative and publicity expenses to fiscal years 1986 through 1988.

Explanation of provision

The targeted job tax credit is available on an elective basis for hiring individuals from nine targeted groups. The targeted groups are: (1) vocational rehabilitation referrals; (2) economically disadvantaged youths aged 18 through 24; (3) economically disadvantaged Vietnam-era veterans; (4) Supplemental Security Income ("SSI") recipients; (5) general assistance recipients; (6) economically disadvantaged cooperative education students aged 16 through 19; (7) economically disadvantaged former convicts; (8) Aid to Families with Dependent Children ("AFDC") recipients and Work Incentive (WIN) registrants; and (9) economically disadvantaged summer youth employees aged 16 or 17. Targeted group membership must be certified.

The credit generally is equal to 40 percent of the first $6,000 of qualified first-year wages paid to a member of a targeted group. Thus, the maximum credit generally is $2,400 per individual. With respect to economically disadvantaged summer youth employees, however, the credit is equal to 85 percent of up to $3,000 of wages, for a maximum credit of $2,550.

The credit is not available for wages paid to a targeted group member unless the individual either (1) is employed by the employer for at least 90 days (14 days in the case of economically disadvantaged summer youth employees), or (2) has completed at least 120 hours of work performed for the employer (20 hours in the case of economically disadvantaged summer youth employees). Also the employer's deduction for wages must be reduced by the amount of the credit.

Under the Omnibus Budget Reconciliation Act of 1987, the credit is no longer available for wages paid to a targeted-group individual who performs the same or substantially similar services as an employee participating in, or affected by, a strike or lockout.

Effect of provision

The targeted jobs tax credit serves as a subsidy to the employer for hiring targeted group members. For example, the targeted jobs credit would provide an effective subsidy of nearly 22 percent of the first-year wages of a full-time employee hired at the minimum wage ($3.65 per hour) by a corporate employer.[12]

Almost 622,000 employees qualified for the targeted jobs tax credit in 1985 (see Table 15). The net increase in U.S. employment is probably less than this amount because some of these employees might have been hired without the credit, and some noncredit eligible employees might have been displaced by the targeted jobs credit program.

The credit appears to be most associated with employment opportunities for economically disadvantaged youth aged 18 to 24. Table 15 shows that almost 60 percent of the employees who became credit eligible in 1985 were economically disadvantaged youth.

TABLE 15.—VOUCHERS AND CERTIFICATIONS BY TARGETED GROUP, FISCAL YEAR 1985 [1]

Targeted group	Vouchers		Certifications	
	Number	Percent [2]	Number	Percent [2]
Economically disadvantaged youths 18 to 24	630,240	46.9	366,711	59.0
Economically disadvantaged Vietnam-era veterans	65,500	4.9	26,478	4.3
Economically disadvantaged former convicts	80,430	6.0	29,880	4.8
Economically disadvantaged summer youth	50,524	3.8	26,923	4.3
General assistance recipients	88,777	6.6	26,716	4.3
SSI recipients	4,835	0.4	2,307	0.4
AFDC recipients and WIN registrants	321,848	24.0	99,637	16.0
Vocational rehabilitation referrals	100,797	7.5	43,237	7.0
Total [3]	1,342,951	100.0	621,889	100.0

[1] A voucher is a preliminary determination that an individual is a member of a targeted group. A certification is a final eligibility determination, issued upon the request of a hiring employee.

[2] Due to rounding, percentages may not add to totals.

[3] Does not include certifications of economically disadvantaged cooperative education students. Such certifications are issued by participating schools rather than State employment security agencies which issue certifications for all other targeted groups.

Source: U.S. Department of Labor.

Table 16 shows that certifications of eligibility for the targeted jobs tax credit more than doubled from 306,000 in 1980 to 622,000 in 1985.

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[12] Assume a corporation hired a member of a targeted group full-time at the minimum wage of $3.65 an hour. Wage payments to the employee would be $7,300 and the credit to the employer would be $2,400. The employer is not permitted to deduct wage payments equal to the amount of the credit so, at a 34 percent tax rate, the effective subsidy would be $1,584.

TABLE 16.—VOUCHERS AND CERTIFICATIONS, 1979–85

	Vouchers (thousands)	Certifications [1] (thousands)
Fiscal year:		
1979	84	37
1980	617	306
1981	734	412
1982	625	202
1983	1,287	431
1984	1,338	563
1985	1,343	622

[1] Does not include certifications of economically disadvantaged cooperative education students. Such certifications are issued by participating schools rather than State employment security agencies which issue certification of all other targeted groups.

Exclusion of Workers' Compensation and Special Benefits for Disabled Coal Miners

Legislative history

Workers' compensation.—Under section 104(a)(1) of the Internal Revenue Code of 1986, workers' compensation benefits generally are not taxable. Present law provides, however, that to the extent workmen's compensation benefits reduce Social Security benefits received, workers' compensation benefits are treated as Social Security benefits (see above). This exclusion from gross income was first codified in the Revenue Act of 1981. The Ways and Means Committee report for that Act suggests that such payments were not subject to tax even prior to the 1918 Act.

The rationale for this exclusion is not offered in the legislative history; however, several arguments frequently are made for maintaining this exclusion. One such argument is that it is inequitable to tax payments that are in lieu of damages under State tort law, while continuing to exclude from income actual damage payments on account of personal injuries or sickness (Code sec. 104(a)(2)). Another argument is that eliminating the exclusions for wage replacement payments would require employers and State and local governments to alter their wage replacement programs to take account of the recipients' tax liability. This could increase the overall expenditures required to maintain these programs. Alternatively, net benefits to recipients might be reduced by the imposition of tax.

Benefits for disabled coal miners.—Payments made to coal miners or their survivors for death or disability resulting from pneumoconiosis (black lung disease) under the Federal Coal Mine Health and Safety Act of 1969 (as amended by the Black Lung Benefits Act of 1972, the Black Lung Benefits Reform Act of 1977, and the Black Lung Benefits Revenue Act of 1981) are excluded from gross income.

Payments made as a result of claims filed before December 31, 1972, originally were excluded from Federal income tax by the Federal Coal Mine Health and Safety Act of 1969. Later payments are excluded from gross income because they are considered to be in the nature of workers' compensation (Rev. Rul. 72-400, 1972-2 C.B. 75).

Explanation of provision

Workers' compensation.—Present law provides that gross income does not include amounts received under workers' compensation acts as compensation for personal injuries or sickness. This exclusion also applies to benefits paid under a workers' compensation act to a survivor of a deceased employee.

Benefits for disabled coal miners.—Under present law, benefits for disabled coal miners (black lung benefits) are not includible in gross income.

There are two types of black lung programs. The first involves Federal payments to coal miners and their survivors due to death or disability, payable for claims filed before July 1, 1973 (Dec. 31, 1973, in the case of survivors). Monthly cash benefits are related to the GS-2 civil service pay scale and number of dependents. This program provided total annual payments of around $1 billion to approximately 295,000 beneficiaries in 1985.[13]

The second program requires coal mine operators to insure payment of black lung benefits for claims filed on or after July 1973 (December 31, 1973, in the case of survivors) in a federally mandated workers' compensation program. Benefits include medical treatment as well as cash payments which, in general, are the same as provided under the program described above. These benefits are paid from a trust fund financed by an excise tax on coal production if there is no responsible operator (an operator for whom the miner worked 1 year) or if the responsible operator is in default. This program provided total annual payments of around $583 million to approximately 164,000 claimants in 1985.[14]

ADDITIONAL STANDARD DEDUCTION FOR THE ELDERLY AND BLIND

Legislative history

From 1954 through 1986, an additional personal exemption was allowed for a taxpayer or a spouse who was 65 years or older at the close of the year. An additional personal exemption also was allowed for a taxpayer or a spouse who was blind. The additional personal exemption was provided because the Congress concluded that the tax law should allow additional tax relief to elderly and blind individuals.

Explanation of provision

Beginning in 1987, the Tax Reform Act of 1986 provides tax relief to the elderly or blind (apart from reduced tax rates) through an additional standard deduction amount, in lieu of an extra personal exemption. The additional amount is $600 for an elderly or a blind individual who is married (whether filing jointly or separately) or is a surviving spouse, and $1,200 for such an individual who is both elderly and blind. An additional standard deduction amount of $750 is allowed for a head of household who is elderly or blind ($1,500, if both), and for a single individual (i.e., an unmarried individual other than a surviving spouse or head of household) who is elderly or blind ($1,500, if both).

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[13] Preliminary numbers from the Statistical Abstract of the United States, 1987.

[14] Ibid.

For elderly or blind taxpayers only, the new basic standard deduction amounts under the 1986 Act (e.g., $5,000 for married individuals filing jointly) and the additional $600 or $750 standard deduction amounts were effective beginning in 1987. For example, for married taxpayers both of whom were 65 or older, the standard deduction in 1987 on a joint return was $6,200. If only one spouse was 65 or older, or blind, the standard deduction in 1987 on a joint return was $5,600. Beginning in 1989, the $600 and $750 additional standard deduction amounts will be adjusted for inflation.

The definitions of elderly and blind status have not been changed since 1954. An elderly person is an individual who has reached or passed 65 years of age. Blindness is defined in terms of the ability to correct a deficiency in distance vision or the breadth of the area of vision. An individual is blind only if central visual acuity is not better than 20/200 in the better eye with correcting lenses, or if visual acuity is better than 20/200, but is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees.

Effect of provision

The additional standard deduction provided by the 1986 Act increases the tax threshold for elderly and blind taxpayers. The additional amount is $1,200 for two elderly individuals on a joint return, raising the tax threshold in 1988 from $8,900 to $10,100. Under prior law, the tax threshold in 1988 for elderly married individuals filing a joint return would have been approximately $8,160, plus an adjustment for inflation during 1987.

More than 78 percent of the beneficiaries of this tax provision have incomes of less than $40,000. As Table 17 shows, these taxpayers receive 71 percent of the tax benefits from the additional standard deduction.

TABLE 17.—DISTRIBUTION OF TAX EXPENDITURE: ADDITIONAL STANDARD DEDUCTION FOR THE ELDERLY AND BLIND, 1989

Income class (thousands)	Returns (thousands)	Amount (millions)
Below $10	53	$4
$10 to $20	1,790	200
$20 to $30	2,361	294
$30 to $40	1,756	278
$40 to $50	790	131
$50 to $75	604	134
$75 to $100	150	39
$100 to $200	47	11
$200 and Over	13	3
Total	7,564	1,094

TAX CREDIT FOR THE ELDERLY AND CERTAIN DISABLED INDIVIDUALS

Legislative history

A tax credit for individuals who are age 65 or over, or who have retired on permanent and total disability, was enacted in the Social Security Amendments of 1983 (Code sec. 22). This credit replaced the previous credit for the elderly, which had been enacted in the Tax Reform Act of 1976. Prior to that provision, the tax law provided a retirement income credit, which initially was enacted in the Internal Revenue Code of 1954.

The retirement income credit was intended to remove inequities between individuals who received retirement income which was not tax-exempt and those who received Social Security payments which were tax-exempt. The retirement income credit was applicable to retirement income only. In 1976, the tax credit for the elderly was enacted to (1) restore the purchasing power of the maximum amount of income eligible for the credit, (2) eliminate the complexity of the retirement income credit, and (3) allow individuals earning any form of income, as well as individuals receiving only retirement income, to qualify for the credit.

In the Social Security Amendments of 1983, the credit for the elderly and permanently and totally disabled was enacted to provide greater equity between Social Security retirement recipients and other retirees with income below certain levels. Because the 1983 amendments provided that one-half of the amount of Social Security benefits is includible in gross income for taxpayers having adjusted gross income (computed with modifications) exceeding $25,000 for single individuals and $32,000 on joint returns, the disparity in tax treatment between Social Security and other retirement payments was lessened for taxpayers with incomes above these thresholds.

Explanation of provision

Individuals who are age 65 or older may claim a nonrefundable income tax credit equal to 15 percent of a base amount. The credit also is available to an individual, regardless of age, who is retired on disability and who was permanently and totally disabled at retirement. For this purpose, an individual is considered permanently and totally disabled ("disabled") if he or she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months. The individual must furnish proof of disability to the IRS.

In computing the amount of the credit, a maximum base amount is specified in the statute, and certain reductions are then made. The statute specifies the initial base amount to be $5,000 in the case of an unmarried elderly or disabled individual, or in the case of a married couple filing a joint return if only one spouse is eligible for the credit; $7,500, in the case of a married couple filing a joint return with both spouses eligible for the credit; or $3,750, in the case of a married couple filing separate returns. For a disabled individual who is under age 65, however, the initial base amount is the lesser of the applicable specified amount or the individual's disability income for the year. Consequently, the maximum credit available is $750 (15 percent of $5,000), $1,125 (15 percent of $7,500), or $562.50 (15 percent of $3,750), depending on the initial base amount applicable to the taxpayer.

The initial base amount is reduced by the amount of certain nontaxable income of the taxpayer, such as nontaxable pension and annuity income or nontaxable Social Security, railroad retirement, or veterans' nonservice-related disability benefits. In addition, the initial base amount is reduced by one-half of the taxpayer's AGI in excess of $7,500, in the case of a single individual; $10,000, in the case of married taxpayers filing a joint return; or $5,000, in the case of married taxpayers filing separate returns. These computational rules reflect that the credit, as indicated above, is designed to provide tax benefits to individuals who receive only taxable retirement or disability income, or who receive a combination of taxable retirement or disability income plus Social Security benefits, that generally are comparable to the tax benefits provided to individuals who receive only Social Security benefits (including Social Security disability benefits).

To illustrate computation of the credit, assume that a husband and wife are both 66 and file a joint return. During the year, the husband receives a taxable pension of $5,000, wages of $3,000, and Social Security benefits of $1,000. The wife receives a taxable pension of $2,000, wages of $1,000, and Social Security benefits of $400. They receive interest income of $200 on savings. The tax credit for the elderly is computed as follows:

Maximum amount upon which credit may be based	$7,500
Less:	
Husband's Social Security benefits	1,000
Wife's Social Security benefits	400
One-half of AGI in excess of $10,000 (½ of $1,200)	600
Total	2,000
Amount on which tax credit is based ($7,500 to $2,000)	5,500
Amount of credit (15 percent of $5,500)	825

Effect of provision

In 1986, $174 million of elderly and disabled credit was claimed. The utilization rate and amount of credit granted has been relatively stable since the program's inception.

TABLE 18.—CREDIT FOR THE ELDERLY AND DISABLED, 1977–90

	Number of families who received credit (thousands)	Total amount of credit (million)	Average credit per return
Calendar year:			
1977	569	$93	$163
1978	689	145	210
1979	607	132	217
1980	562	135	240
1981	474	124	262
1982	483	131	271
1983	423	116	275
1984	475	107	225
1985 [1]	460	106	230
1986 [1]	498	174	349
1987 [2]	627	151	241
1988 [2]	623	164	263
1989 [2]	611	163	269
1990 [2]	529	139	263

[1] Preliminary.
[2] Estimated.

More than 99 percent of the beneficiaries of this tax provision have incomes of less than $40,000. As Table 19 shows, these taxpayers receive almost 100 percent of the tax benefits from the tax credit for the elderly and disabled.

TABLE 19.—DISTRIBUTION OF TAX EXPENDITURE: CREDIT FOR THE ELDERLY AND DISABLED, 1989

Income class (thousands)	Returns (thousands)	Amount (millions)
$0 to $10	103	$32
10 to 20	382	96
20 to 30	58	12
30 to 40	4	1
40 to 50		
50 to 75		
75 to 100		
100 to 200		
200 and over		
Total	543	140

MEASUREMENT OF TAX EXPENDITURES

Estimates of tax expenditures as revenue losses are subject to important limitations. Each tax expenditure is measured in isolation. The difference between the estimate of tax liabilities under present law, which provides for a tax preference, and the higher level of tax liabilities if the provision did not exist, is the amount of tax expenditure. For this computation, it generally is assumed that nothing else changes.

If two or more items were to be eliminated simultaneously, the result of the combintion of changes might produce a lesser or greater revenue effect than the sum of the amount shown for each item separately. This means that adding the amounts of various tax expenditure items is of quite limited usefulness.

If a tax expenditure item were to be eliminated, it is possible that Congress would deal with the underlying reason for enacting the tax expenditure in another way, rather than simply terminating Federal assistance of any kind. To the extent that a replacement program would be adopted, the higher revenues received as result of the elimination of a tax expenditure might not represent a net budget gain. The nature of any alternative program cannot be anticipated: it could involve direct expenditures, direct loans, or loan guarantees; or it could involve a different form of tax expenditure, or a general reduction in tax rates. If any of these provisions were repealed, adjustment might be made through fiscal or monetary policy to offset the effects of higher tax liabilities on the economy, but the estimates of tax expenditures do not anticipate such policy responses.

CONCEPTS USED IN DISTRIBUTIONAL ANALYSIS

Unless otherwise specified, the income concept used to show the distribution of tax expenditures by income class is adjusted gross income plus (1) tax-exempt interest, (2) employer contributions for health plans and life insurance, (3) inside build-up on life insurance, (4) workers' compensation, (5) nontaxable Social Security benefits, (6) deductible contributions to individual retirement accounts, (7) minimum tax preferences, and (8) net losses, in excess of minimum tax preferences, from passive business activities (such as limited partnership activities).

This definition of income represents an attempt to include items which clearly increase the ability to pay taxes, but which are not included in the present-law definition of adjusted gross income. The adjustment for losses from certain passive business activities takes into account that investments in such activities may result in losses for tax purposes that do not represent economic losses.

This income definition is subject to various limitations. It omits certain items which clearly affect ability to consume goods and services, including accrual of pension benefits, other fringe benefits (such as military benefits, veterans benefits, and parsonage allowances), means-tested transfer payments (such as Aid to Families with Dependent Children, Supplemental Security Income, food stamps, housing subsidies, and general assistance), and imputed rent on owner-occupied homes.

All income and deduction items and tax parameters are projected to 1989 levels based on economic assumptions consistent with the February 1988 forecast of the Congressional Budget Office.

The tax return is the unit of analysis in all tables, so that each income class consists of tax returns with the stated amount of income.

Unless specifically indicated, all distributional tables exclude taxpayers under age 16.

APPENDIX G. DEMOGRAPHIC AND ECONOMIC CHARACTERISTICS OF FAMILIES WITH CHILDREN [1]

INTRODUCTION

This appendix describes changes in the demographic and economic characteristics of families with children. It covers a variety of topics related specifically to these families, including:

—the changing composition of families,
—the living arrangements of children,
—teenage birth rates,
—the labor force participation of women,
—child care,
—earnings and other income sources of families with children,
—the Federal tax treatment of families in poverty, and
—the impact of means-tested programs and Federal tax policy on the disposable income of female-headed families.

CHANGING FAMILY COMPOSITION [1]

As table 1 demonstrates, the number of one-parent families with children has increased rapidly over the past one and one-half decades. This trend is largely the result of higher divorce and lower remarriage rates and an increase in the number of never-married mothers. At the same time, the number of two-parent families with children has actually declined, due partly to lower marriage rates as individuals opt not to marry or opt to postpone marriage. Between 1970 and 1986, the number of one-parent families increased 135 percent, growing from 3.8 to 8.9 million. Over the same period, the number of two-parent families decreased 3.1 percent, falling from 25.8 to 25.0 million.

As a result of these trends, the composition of families in the United States has changed. Whereas in 1970 two-parent families accounted for 87 percent of all families with children, in 1986 these families accounted for 74 percent of all families with children.

The decline in the incidence of two-parent families is especially pronounced among the black population. The proportion of white families maintained by two parents declined from 90 percent in 1970 to 79 percent in 1986, while the proportion of black families maintained by two parents declined from 64 percent in 1970 to 42 percent in 1986. One should note, however, that although the incidence of one-parent families is higher among blacks than whites, a majority of all one-parent families with children is white. In 1986, 67 percent of all families maintained by one parent was white.

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[1] This section borrows heavily from a CRS print entitled "Statistical and Program Data on Single-Parent Families with Children," by Carmen D. Solomon.

The majority of one-parent families is headed by a female. In 1986, 88 percent of all one-parent families with children were maintained by the mother, while 12 percent were maintained solely by the father. This percentage breakdown has changed only slightly since 1970.

The marital status of women who maintain one-parent families has changed dramatically over the period from 1970 to 1986. In 1970, only 7 percent of women maintaining families alone could be classified as having never been married, compared to 29 percent in 1986. Further, by 1986, a greater proportion of those women heading families who had ever married could be classified as having been divorced: in 1970, 35 percent of women in this group were divorced, compared with 59 percent in 1986.

TABLE 1.—TWO-PARENT AND ONE-PARENT FAMILIES AS PROPORTIONS OF ALL FAMILIES WITH CHILDREN PRESENT, BY RACE: 1970, 1980, 1985 AND 1986

Subject	All races				White		Black	
	1970	1980	1985	1986	1970	1986	1970	1986
	Number in thousands							
Total with children under 18	29,631	32,150	33,372	33,939	26,115	28,041	3,219	4,772
Two-parent family groups	25,823	25,231	24,573	25,010	23,477	22,076	2,071	2,022
One-parent family groups	3,808	6,920	8,779	8,930	2,638	5,964	1,148	2,752
Maintained by mother	3,415	6,230	7,737	7,842	2,330	5,070	1,063	2,597
Never married	248	1,063	2,208	2,276	73	885	173	1,355
Spouse absent	1,377	1,743	1,732	1,724	796	1,129	570	546
Separated	962	1,483	1,524	1,506	477	972	479	510
Divorced	1,109	2,721	3,228	3,294	930	2,676	172	561
Widowed	682	703	569	546	531	380	148	133
Maintained by father	393	692	1,042	1,088	307	894	85	155
	Percent distribution							
Total with children under 18	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Two-parent family groups	87.1	78.5	73.6	73.7	89.9	78.7	64.3	42.4
One-parent family groups	12.9	21.5	26.3	26.3	10.1	21.3	35.7	57.7
Maintained by mother	11.5	19.4	23.2	23.1	8.9	18.1	33.0	54.4
Never married	0.8	3.3	6.6	6.7	0.3	3.2	5.4	28.4
Spouse absent	4.6	5.4	5.2	5.1	3.0	4.0	17.7	11.4
Separated	3.2	4.6	4.6	4.4	1.8	3.5	14.9	10.7
Divorced	3.7	8.5	9.7	9.7	3.6	9.5	5.3	11.8
Widowed	2.3	2.2	1.7	1.6	2.0	1.4	4.6	2.8
Maintained by father	1.3	2.2	3.1	3.2	1.2	3.2	2.6	3.2

Note: Family groups consist of family households, related subfamilies, and unrelated subfamilies.

Source: U.S. Bureau of the Census, Current Population Reports, Series P–20, No. 419, Household and Family Characteristics: March 1986. Washington, U.S. Govt. Print. Off., 1987, pp. 9 and 10.

LIVING ARRANGEMENTS OF CHILDREN

Tables 2 and 3 below describe trends in the living arrangements of children. The changing composition of families over the 1970 through 1986 period directly affected the living arrangements of children. Although the total number of children under age 18 years old in the United States declined from 69 to 63 million, the proportion of children affected by the divorce or separation of their parents, or the unmarried status of their mother, grew considerably. As a result, both the number and proportion of children living in one-parent families increased dramatically between 1970 and 1986. The number of children living with one parent grew 80 percent, from 8.2 to 14.8 million. Over 23 percent of all children lived in one-parent families in 1986, compared with 12 percent in 1970. These aggregate figures do not reveal the significant differences for black and white children. In 1986, 18 percent of all white children under age 18 and 53 percent of all black children under age 18 lived with one parent.

In both 1970 and 1986, the majority of children in one-parent families lived with a mother rather than a father, and the percentage breakdown changed only slightly during this period. Of children living with one parent, 90.9 percent lived with their mother in 1970, compared with 89.3 percent in 1986. Between 1970 and 1986, the number of children living with only a father grew from 0.7 million to 1.6 million. The proportion of all children in one-parent families living with a father grew from 1.1 to 2.5 percent.

As one would expect from the data presented in the previous subsection, a greater proportion of children in one-parent families lived with a divorced or never-married parent in 1986 compared with 1970. In 1986, 42 percent of children in one-parent families lived with a divorced parent, representing more than double the 1970 number; 27 percent lived with a parent who had never been married, representing nearly 7 times the 1970 number.

The data in the above paragraphs present a snapshot of the living arrangements of children at a given point in time. However, a snapshot approach can be misleading for several reasons, three of which are described here.[2] [3] One, snapshot data understate the number of children who will spend at least some time in a single-parent home. Based on current trends, it is estimated that 70 percent of white children and 94 percent of black children born in 1980 will spend part of their childhood in a single-parent home before the age of 18. These lifetime prevalence data present a much different view than do the snapshot data. Two, in one respect the snapshot approach overstates differences between blacks and whites. On average, blacks become mothers at an earlier age and are also less likely to marry or remarry than whites. As a result, snapshot data is closer to lifetime prevalance data for blacks than it is for whites. Although the snapshot data illustrate that the proportion of children living in a single-parent home is three times greater for blacks than whites, the lifetime prevalence data is only

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[2] The discussion in this paragraph is from "Single Mothers and Their Children," by Irwin Garfinkel and Sara S. McLanahan, The Urban Institute, 1986.

[3] Data are based on the PSID, and are found in "Updating Children's Life Course," by Sandra Hofferth, "Journal of Marriage and Family," February 1985.

35 percent higher for blacks than it is for whites. Three, the snapshot approach does not give any indication of the length of time that children tend to spend in a single-parent home. The length of time spent in a single-parent home is much higher for black children since their mothers tend to have lower marriage and remarriage rates. It is estimated that black children born in 1980 will on average spend 59 percent of their childhood in a single-parent family; white children born in 1980 can expect to spend 31 percent of their childhood in a single-parent family.

TABLE 2.—LIVING ARRANGEMENTS OF CHILDREN UNDER 18 YEARS: 1970, 1980, 1985, AND 1986

[Excludes persons under 18 years old who maintain households or family groups]

Living arrangements of children and marital status of parent	All races				1986 by race		
	1970	1980	1985	1986	White	Black	Hispanic orgin [1]
	Numbers in thousands						
ALL CHILDREN UNDER 18 YEARS							
Total	69,162	63,427	62,475	62,763	50,931	9,532	6,430
Living with:							
Two parents	58,939	48,624	46,149	46,384	40,681	3,869	4,275
One parent	8,199	12,466	14,635	14,759	9,303	5,058	1,955
Mother only	7,451	11,406	13,081	13,180	8,021	4,827	1,784
Father only	748	1,060	1,554	1,579	1,282	231	171
Other relatives only	1,547	1,949	1,303	1,348	747	542	162
Nonrelatives only	477	388	388	272	200	63	38
	Percent distribution						
Percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Living with:							
Two parents	85.2	76.7	73.9	73.9	79.9	40.6	66.5
One parent	11.9	19.7	23.4	23.5	18.3	53.1	30.4
Mother only	10.8	18.0	20.9	21.0	15.7	50.6	27.7
Father only	1.1	1.7	2.5	2.5	2.5	2.4	2.7
Other relatives only	2.2	3.1	2.1	2.1	1.5	5.7	2.5
Nonrelatives only	0.7	0.6	0.6	0.4	0.4	0.7	0.6

TABLE 2.—LIVING ARRANGEMENTS OF CHILDREN UNDER 18 YEARS: 1970, 1980, 1985, AND 1986—Continued

[Excludes persons under 18 years old who maintain households or family groups]

Living arrangements of children and marital status of parent	All races				1986 by race		
	1970	1980	1985	1986	White	Black	Hispanic orgin [1]
	Numbers in thousands						
CHILDREN LIVING WITH ONE PARENT							
Total	8,199	12,466	14,635	14,759	9,303	5,058	1,955
Marital status of parent:							
Never married	557	1,820	3,756	3,924	1,377	2,478	491
Married, spouse absent	3,521	3,898	3,750	3,643	2,312	1,203	729
Separated	2,484	3,327	3,291	3,230	2,029	1,125	658
Widowed	1,649	1,469	1,101	1,047	706	265	102
Divorced	2,473	5,281	6,030	6,146	4,907	1,114	631
	Percent distribution						
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Marital status of parent:							
Never married	6.8	14.6	25.7	26.6	14.8	49.0	25.1
Married, spouse absent	42.9	31.3	25.6	24.7	24.9	23.8	37.3
Separated	30.3	26.7	22.5	21.9	21.8	22.2	33.7
Widowed	20.1	11.8	7.5	7.1	7.6	5.2	5.2
Divorced	30.2	42.4	41.2	41.6	52.7	22.0	32.3

[1] Persons of Hispanic origin may be of any race.

Source: U.S. Bureau of the Census. Current Population Reports, Series P–20, No. 418. Marital Status and Living Arrangements: March 1986. Washington, U.S. Govt. Printing. Off., 1987, tables E and F.

TABLE 3.—STATUS OF CHILDREN: 1960–1986

[In thousands]

	1960	1970	1975	1980	1985	1986
Children under 18:						
Total in population	63,727	69,162	64,165	63,427	62,475	63,271
Living with 1 parent	5,832	8,199	11,245	12,466	14,635	14,759
As percent of all children	9.2	11.9	17.5	19.7	23.4	23.3
Living with never-married parent	243	557	1,198	1,820	3,756	3,924
As percent of all children	.4	.8	1.9	2.9	6.0	6.2
Receiving Aid to Families with Dependent Children [1]	2,314	6,214	8,095	7,419	7,198	7,334

[1] Includes some children ages 18 to 22.

Source: Based on Census and DHHS publications.

TEENAGE BIRTH RATES

Between the early 1960's and 1976, the birth rates of both white and black women ages 15 to 19 declined significantly. As table 4 shows, the birth rate of white women ages 15 to 19 fell from 79.4 (births per 1,000 women in the age group) in 1960 to 44.1 in 1976, representing an average annual decline in the birth rate of 3.6 percent. The birth rate of black women ages 15 to 19 fell from 147.6 in 1964 (the earliest year for which data are available) to 104.9 in 1976, representing an average annual decline of 2.8 percent (the birth rate of white women declined at an average annual rate of 3 percent over this same 1964 to 1976 period).

Although the birth rates of both blacks and whites ages 15 to 19 continued to decline after 1976, the decline was considerably slower than it was over the 1960 to 1976 period, and slower for whites than for blacks. The birth rate of white women fell from 44.1 in 1976 to 42.8 in 1985, representing an average annual decline of one-third of 1 percent. The birth rate of black women fell from 104.9 in 1976 to 97.4 in 1985, representing an average annual decline of seven-tenths of 1 percent.

Table 5 provides birth rate data broken down by marital status and race of the mother. This table illustrates that decreasing birth rates of young women are driven largely by the decreasing birth rates of married young women. In absolute terms, the birth rates of married women ages 15 to 19 fell dramatically in the 1970's, while the number of births and birth rates of unmarried women fell less dramatically among blacks and actually increased among whites.

From these aggregate data, one cannot conclude why the birth rate for young unmarried women has not decreased. The rate of births to unmarried women depends not only on the rate of conception out of wedlock (which depends on sexual activity and contraceptive practice), but also on the use of abortion and prenatal marriage rates (the classification of a birth as in or out of wedlock depends on the marital status of the mother at the time of birth, not at the time of conception).

Data on the number and percent of children conceived out of wedlock whose mothers marry sometime before giving birth are not available on an annual basis. However, some information is available from special surveys and analyses and is presented in table 6. This table shows that between the two periods 1959–1962 and 1975–1978, the percent of premaritally conceived children whose 15- to 17-year-old mothers married before giving birth fell from 16 percent to 5 percent for black women, and from 70 percent to 56 percent for white women. For women ages 18 and 19, the trend downward was even sharper. Thirty-four percent of all children conceived out of wedlock among black women in this age group were born in wedlock in the 1959–1962 period, compared to 11 percent in 1975–1978; 73 percent of all children conceived out of wedlock among white women in this age group were born in wedlock in the 1959–1962 period, compared to 60 percent in 1975–1978.

As a result of the decreasing birth rate for young married women and the increasing birth rate for young unmarried women, a greater proportion of all births to young women are premarital (see table 7). This has occurred even though, as shown above, the overall number of births to young women and the overall birth rate for young women have declined.

TABLE 4.—NUMBER OF BIRTHS AND BIRTH RATES TO WOMEN AGES 15 TO 19, 1960 TO 1985

Year	Number of births, all women under 20		Birth rate [1]					
			All women 15 to 19		15 to 17		18 to 19	
	White	Black	White	Black	White	Black	White	Black
1960			79.4					
1961			79.2					
1962			73.2					
1963			68.2					
1964			63.4	147.6				
1965			60.6	144.6				
1966			60.4	142.7	26.6	97.9	108.2	219.2
1967			56.9	141.8	25.7	99.5	104.0	213.4
1968			54.9	138.7	25.6	98.2	100.5	206.1
1969	437,958	168,588	54.7	137.0	26.4	96.9	99.2	202.5
1970	467,928	179,100	57.4	147.7	29.2	101.4	101.5	204.9
1971	450,856	178,948	53.6	134.5	28.5	99.4	92.3	192.6
1972	438,559	179,712	51.0	129.8	29.3	99.5	84.3	179.5
1973	429,570	176,551	49.0	123.1	29.2	96.0	79.3	166.6
1974	425,205	171,721	47.9	116.5	28.7	90.0	77.3	158.7
1975	415,202	168,359	46.4	111.8	28.0	85.6	74.0	152.4
1976	389,329	160,597	44.1	104.9	26.3	80.3	70.2	142.5
1977	396,854	161,772	44.1	104.7	26.1	79.6	70.5	142.9

TABLE 4.—NUMBER OF BIRTHS AND BIRTH RATES TO WOMEN AGES 15 TO 19, 1960 TO 1985—Continued

Year	Number of births, all women under 20		Birth rate [1]					
			All women 15 to 19		15 to 17		18 to 19	
	White	Black	White	Black	White	Black	White	Black
1978..	384,572	157,069	42.9	100.9	24.9	75.0	69.4	139.7
1979..	388,209	158,944	43.7	101.7	24.7	75.7	71.0	140.4
1980..	392,229	156,146	44.7	100.0	25.2	73.6	72.1	138.8
1981..	373,983	148,703	44.6	97.1	25.1	70.6	71.9	135.9
1982..	362,101	145,929	44.6	97.0	25.2	71.2	70.8	133.3
1983..	342,183	142,105	43.6	95.5	24.8	70.1	68.3	130.4
1984..	320,953	134,392	42.5	95.7	23.9	69.7	68.1	132.0
1985..	322,826	140,130	42.8	97.4	24.0	69.8	70.1	137.1

[1] Births per 1,000 women in the age group.

Sources: U.S. National Center for Health Statistics. Vital Statistics of the United States, 1979: Natality. Table 1-6. U.S.C. National Center for Health Statistics. Monthly Vital Statistics Report: Advance Report of Final Natality Statistics. 1982, 1983, 1984, and 1985, Table 3.

TABLE 5.—ESTIMATED BIRTH RATES FOR MARRIED AND UNMARRIED WOMEN AGES 15–19, BY RACE: 1966 TO 1985

[Births per 1,000 women]

Year	Marital status, race, and age					
	Married		Unmarried			
			White		Black	
	White, 15 to 19	Black, 15 to 19	15 to 17	18 to 19	15 to 17	18 to 19
1966	438.8		5.4	14.1		
1967	424.1		5.6	15.3		
1968	422.0		6.2	16.6		
1969	423.1	514.6	6.6	16.6	72.0	128.4
1970	431.8	533.3	7.5	17.5	77.9	136.4
1971	403.4	511.7	7.4	15.8	80.9	136.3
1972	364.1	500.0	8.1	15.1	83.1	129.8
1973	330.6	453.7	8.5	15.0	81.9	123.0
1974	320.1	372.4	8.9	15.4	79.4	124.9
1975	311.8	329.8	9.7	16.6	77.8	126.8
1976	306.4	319.2	9.9	17.0	74.6	121.8
1977	307.6	345.7	10.7	18.8	74.3	125.9
1978	321.8	368.6	10.5	19.5	70.3	124.3
1979	337.6	333.8	11.1	21.2	72.5	128.8
1980	348.6	360.2	11.8	23.6	69.5	120.2

TABLE 5.—ESTIMATED BIRTH RATES FOR MARRIED AND UNMARRIED WOMEN AGES 15–19, BY RACE: 1966 TO 1985—Continued

[Births per 1,000 women]

Year	Marital status, race, and age					
	Married		Unmarried			
			White		Black	
	White, 15 to 19	Black, 15 to 19	15 to 17	18 to 19	15 to 17	18 to 19
1981	332.9	380.7	12.4	24.6	66.9	117.6
1982			12.9	25.1	67.6	115.8
1983			13.5	26.1	67.1	114.0
1984			13.5	27.6	66.8	116.2
1985			14.2	30.9	67.0	121.1

Sources: U.S. National Center for Health Statistics, Vital Statistics of the United States, 1979: Natality, 1–32 and 1–33. And U.S. National Center for Health Statistics Monthly Vital Statistics Report: Advance Report of Final Natality Statistics, 1982, 1983, 1984 and 1985, Table 19.

TABLE 6.—PERCENT OF CHILDREN CONCEIVED OUT OF WEDLOCK WHO ARE BORN IN WEDLOCK TO WOMEN AGES 15 TO 17 AND 18 TO 19, 1959–78 [1]

	Percent of premaritally conceived births by race and age of mother			
	White		Black	
	15 to 17	18 to 19	15 to 17	18 to 19
1959 to 1962	69.8	72.7	16.0	33.6
1963 to 1966	64.3	75.8	18.4	37.1
1967 to 1970	62.9	75.9	21.3	32.3
1971 to 1974	52.9	74.4	15.1	20.2
1975 to 1978	55.8	60.4	4.9	10.7

[1] Includes first births only.

Source: O'Connell, Martin and Maurice J. Moore. The Legitimacy Status of First Births to U.S. Women Aged 15 to 24, 1939–1978. Family Planning Perspectives, vol. 12, No. 1. January–February, p. 18.

TABLE 7.—PERCENTAGE BREAKDOWN OF PREMARITAL VS. POSTMARITAL TEENAGE BIRTHS, BY AGE OF MOTHER, 1959–78 [1]

	15–17 yrs old		18–19 yrs old	
	Premarital	Postmarital	Premarital	Postmarital
White women:				
1959–62	14.0	86.0	6.6	93.4
1963–66	19.9	80.1	8.6	91.4
1967–70	25.4	74.6	10.9	89.1
1971–74	34.5	65.5	13.6	86.4
1975–78	35.5	64.5	20.8	79.2
Black women:				
1959–62	75.0	25.0	44.4	55.6
1963–66	72.9	27.1	41.8	58.2
1967–70	70.2	29.8	54.1	45.9
1971–74	80.0	20.0	70.2	29.8
1975–78	92.9	7.1	75.8	24.2

[1] Includes first births only.

Source: Derived from: O'Connell, Martin, and Maurice J. Moore, "The Legitimacy Status of First Births to U.S. Women aged 15 to 24, 1939–1978," Family Planning Perspectives, vol. 12, No.1. January/February 1980, p. 18.

LABOR FORCE PARTICIPATION OF WOMEN WITH CHILDREN

HISTORICAL DATA ON THE LABOR FORCE PARTICIPATION OF WOMEN [4]

A person is defined as participating in the labor force if he or she is working full-time, working part-time or actively seeking work. Over the last two decades, the proportion of mothers who participate in the labor force has increased markedly as a result of both noneconomic factors (e.g., changing attitudes in society and the desire of women to work) and economic factors (e.g., growing wage rates for women).

Table 8 presents historical data on the labor force participation rates of women with children for selected years between 1960 and 1987. As this table shows, the percent of all women with children in the labor force has increased from 30 percent in 1960, to 53 percent in 1970, to 65 percent in 1987. Overall, the most dramatic changes in labor force participation occurred for married women. The labor force participation rate for married women whose youngest child was less than 6 grew 87 percent between 1970 and 1987; the rate for married women whose youngest child was older than 6 grew 43 percent. Further, except for rates among widowed women, participation rates grew fastest for women whose youngest child was less than 6.

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[4] This section borrows heavily from: Bureau of National Affairs, No. 155, August 1987, and "Women in the Work Force," U.S. Department of Commerce, Bureau Series P-23, No. 146, November 1986.

TABLE 8.—LABOR FORCE PARTICIPATION RATES OF WOMEN WITH CHILDREN, BY MARITAL STATUS AND AGE OF YOUNGEST CHILD, 1960 TO 1987

[In percent]

	1960	1970	1980	1986	1987	Percent Increase, 1970–87
All women with children	[1] 30.4	[1] 52.9	56.6	62.8	64.7	22.3
Married women:						
Youngest under 6	18.6	30.3	45.0	53.8	56.8	87.5
Youngest 6 or over	39.0	49.2	61.8	68.4	70.6	43.5
Separated women:						
Youngest under 6	NA	45.4	52.2	57.4	55.1	21.4
Youngest 6 or over	NA	60.6	66.6	70.6	72.6	19.8
Divorced women:						
Youngest under 6	NA	63.3	68.3	73.8	70.5	11.4
Youngest 6 or over	NA	82.4	82.3	84.7	84.5	2.5
Never-married women:						
Youngest under 6	NA	NA	44.1	47.5	49.9	NA
Youngest 6 or over	NA	NA	67.6	65.9	64.1	NA
Widowed women:						
Youngest under 6	NA	36.8	44.7	46.4	38.5	4.6
Youngest 6 or over	NA	55.3	60.7	57.5	60.1	8.7

[1] Excludes never-married women.

Source: "The Welfare Reform Debate As It Will Confront The Next President" by Robert D. Reischauer, The Brookings Institution, February 1988. Data from Bureau of the Census, Statistical Abstract of the United States, 1987, Table 654 and Department of Labor Bulletin No. 2175, Table 56, page 125; B.L.S. News Release USDL 86–345, August 20, 1986, USDL 84–321, July 26, 1984, USDL 87–345 August 12, 1987, Table 3; and Department of Labor, BLS, Special Labor Force Report, Marital and Family Characteristics of Workers, March 1960, April 1961, Table G.

DETAILED DATA ON THE LABOR FORCE PARTICIPATION OF WOMEN IN 1987

Table 9 provides a more detailed breakdown of the labor force participation of women for March of 1987 only, by marital status and the age of the youngest child. Among those with children under 18, divorced women have the highest labor force participation rates, followed by married and separated women. Widowed and never-married women have lower labor force participation rates.

As this table illustrates, no matter what the marital status of the woman, labor force participation rates tend to increase as the age of the youngest child increases. For example, among all women with children under 18, 53 percent of those with a child under 3 participate, 62 percent of those whose youngest child is between 3 and 5 participate, and 72 percent of those whose youngest child is between 6 and 17 participate.

TABLE 9.—LABOR FORCE PARTICIPATION RATES OF WOMEN WITH CHILDREN UNDER 18, MARCH 1987, BY MARITAL STATUS AND AGE OF YOUNGEST CHILD

	Age of youngest child						
	Under 3	Under 6	Under 18	3 to 5	6 to 13	6 to 17	14 to 17
All women with child under 18	52.9	56.7	64.7	62.4	71.6	72.0	72.9
Married, spouse present	54.2	56.8	63.8	61.0	70.5	70.6	70.7
Divorced	57.9	70.5	80.4	78.2	83.4	84.5	86.6
Separated	48.6	55.1	64.8	62.1	71.6	72.6	74.8
Widowed	(1)	(1)	57.4	(1)	54.2	60.1	66.9
Never-married	44.8	49.9	54.1	59.2	63.7	64.1	66.4

[1] Data not shown where base is less than 75,000.

Source: Department of Labor, Bureau of Labor Statistics, USDL 87-345, August 1987.

TYPE OF LABOR FORCE PARTICIPATION OF WOMEN [5]

While there has been a substantial increase in the proportion of mothers in the labor force, these aggregate data can be misleading. As table 10 shows, although 62 percent of mothers participated in the labor force in 1986, 41 percent worked full time, 16 percent worked part time, and 6 percent were actively seeking a job. (Full time work is defined as 35 or more hours per week; part time work is defined as 34 hours or less.) Thirty-three percent of mothers with children under age 6 worked full time, and 15 percent worked part time.

Note that even these disaggregated numbers can be misleading. "Full time" means full time for any period during the calendar year, and not necessarily full time for the full year. "Part time" means anything from a few hours a week during the Christmas season up to 34 hours a week year round. Only 29 percent of married mothers worked full time for a full year. An additional 8 percent of them worked full time 27 to 49 weeks a year; 7 percent worked full time from 1 to 26 weeks a year (these data do not appear in the table).

As table 10 demonstrates, whether and how much mothers work differs according to their marital status and the age of their children. Thirty-nine percent of married women with children worked full time; thus, close to 60 percent either didn't work at all or worked part-time. Some 63 percent of all divorced mothers worked full time; 50 percent of divorced mothers with children under 6 worked full time. Only 29 percent of never-married mothers worked full time, and only 8 percent worked part time. When contrasted with divorced mothers, their closest counterpart as female heads of households, never-married mothers were half as likely to work full time. Of many factors that can partially account for these differences, we know that unmarried mothers are, on average, younger and less educated than divorced mothers.

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[5] This section borrows heavily from "How Much Are Working Mothers Working?" Public Opinion, November/December 1986, by Douglas Besharov and Michelle Dally.

TABLE 10.—WORKING MOTHERS' WORK, MARCH 1986

[In percent]

	With children 0 to 17	With children under 6
All mothers:		
Full time	41	33
Part time	16	15
Married, spouse present:		
Full time	39	33
Part time	18	17
Divorced:		
Full time	63	50
Part time	11	14
Never married:		
Full time	29	23
Part time	8	8

Source: "How Much Are Working Mothers Working?"; Douglas J. Besharov and Michelle M. Dally; Public Opinion, November/December 1986.

Table 11 presents data for 1977, 1982 and 1987 on the number and percent of children under 18 with a mother in the labor force, by various family types. In 1987, 60 percent of all children under 18 had a mother in the labor force, compared with 48 percent in 1977. Of all children under age 6, 53 percent had a mother in the labor force in 1987, compared with 38 percent in 1977.

TABLE 11.—NUMBER AND AGE OF OWN CHILDREN UNDER 18 YEARS OLD WITH A MOTHER IN THE LABOR FORCE, BY FAMILY TYPE, MARCH 1977, 1982, AND 1987

[Numbers in thousands]

Age of children and family type	1977		1982		1987	
	Number	Percent of total	Number	Percent of total	Number	Percent of total
Total children under 18 years old	28,892	47.7	32,008	54.9	35,170	60.2
6 to 17 years	22,462	51.7	23,534	59.1	24,657	63.8
Under 6 years	6,431	37.6	8,473	45.8	10,513	53.1
1 year or younger	1,721	31.1	2,640	41.6	3,248	50.2
2 years	1,052	38.4	1,472	46.9	1,750	53.6
3 years	1,056	38.4	1,476	48.4	1,760	53.6
4 years	1,235	42.3	1,461	48.5	1,846	54.5
5 years	1,366	43.0	1,424	48.2	1,908	56.2
In married-couple families	23,341	46.4	25,130	54.3	27,870	61.3
6 to 17 years	17,930	50.5	30,908	58.7	19,113	65.1
Under 6 years	5,411	36.6	7,000	45.5	8,756	54.4
1 year or younger	1,542	31.2	2,312	42.2	2,836	52.1
2 years	898	37.6	1,225	47.1	1,478	55.5
3 years	878	37.3	1,203	47.9	1,444	53.8

TABLE 11.—NUMBER AND AGE OF OWN CHILDREN UNDER 18 YEARS OLD WITH A MOTHER IN THE LABOR FORCE, BY FAMILY TYPE, MARCH 1977, 1982, AND 1987—Continued

[Numbers in thousands]

Age of children and family type	1977		1982		1987	
	Number	Percent of total	Number	Percent of total	Number	Percent of total
4 years	995	40.8	1,133	47.4	1,503	55.5
5 years	1,098	41.4	1,127	47.0	1495	57.2
In families maintained by woman	5,551	58.4	6,878	62.7	7,301	63.5
6 to 17 years	4,532	62.4	5,405	66.8	5,543	67.8
Under 6 years	1,020	45.7	1,473	51.2	1,757	53.0
1 year or younger	179	32.4	328	42.2	412	45.7
2 years	154	46.2	247	49.9	272	51.0
3 years	178	46.8	273	55.6	316	57.4
4 years	240	52.5	328	55.9	343	56.3
5 years	268	52.7	297	56.5	413	57.5

Source: Department of Labor, Bureau of Labor Statistics.

CHILD CARE

Because of the huge increase in the number of employed mothers, child care has become an important issue. As noted in the previous subsection, the majority of all children now have a mother who works either full- or part-time, or is actively seeking work. This section presents data on the child care arrangements of working mothers with children under age 15, presents data on employers' child care practices and policies, and describes the federal role in child care.

PRIMARY CHILD CARE ARRANGEMENTS BY MARITAL AND EARNINGS STATUS OF THE MOTHER [6]

"Primary child care arrangement" refers to the arrangement used most frequently during a typical work week. Table 12 shows the distribution of the primary child care arrangements provided for preschoolers (children under 5 years old) and grade-school-age children (5 to 14 years old) during the winter of 1984–85, by marital and earnings status of the employed mother.

This table illustrates that of the 8.2 million preschool-age children of working women, 23 percent attended day care centers or preschools most of the time their mothers were at work. The remainder were primarily in supervised care in their own home (31 percent) or in someone else's home (37 percent), or cared for by the mother herself while at work (8 percent). About 75 percent of the 18.3 million grade school children were in school most of the hours their mothers were at work. An additional 12 percent were cared for in their own home.

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[6] This and the following two subsections borrow heavily from "Who's Minding the Kids?, Child Care Arrangements, Winter 1984–85," U.S. Department of Commerce, Bureau of the Census, Series P-70, No. 9, May 1987. Data on the child care arrangements of working mothers are based on the Survey of Income and Program Participation (SIPP). These data were obtained for the three youngest children under 15 years old in the household. These data represent approximately 90 percent of all children under 15 years old with working mothers.

Considerably different patterns of child care usage are noted among women depending on their weekly work schedule. The hourly demands for child care services placed upon families with full-time working mothers cannot normally be met by other household members or relatives. As a result, the location of child care activities for full-time working mothers is more likely to be outside of the child's home and with nonrelatives.

TABLE 12.—PRIMARY CHILD CARE ARRANGEMENTS OF CHILDREN UNDER 15 WITH AN EMPLOYED MOTHER, BY MARITAL AND EMPLOYMENT STATUS OF THE MOTHER, WINTER 1984–85

[Numbers in thousands]

Marital status of mother and type of child care arrangement	Mothers with children under 5 years			Mothers with children 5 to 14 years		
	Total	Employed full time	Employed part time	Total	Employed full time	Employed part time
All marital statuses:						
Number of children	8,168	5,060	3,108	18,287	11,752	6,535
Percent	100.0	100.0	100.0	100.0	100.0	100.0
Care in child's home	31.0	24.4	41.8	11.8	10.6	14.1
By father	15.7	10.7	23.8	6.6	5.0	9.5
By other relative	9.4	8.7	10.7	4.0	4.4	3.4
By nonrelative	5.9	5.0	7.3	1.1	1.1	1.1
Care in another home	37.0	42.2	28.4	4.3	4.6	3.7
By relative	14.7	14.7	14.7	2.2	2.4	1.9
By nonrelative	22.3	27.5	13.8	2.1	2.2	1.8
Organized child care facilities	23.1	28.0	15.2	2.8	3.6	1.6
Day/group care center	14.0	16.5	9.9	1.6	2.0	1.0
Nursery school/preschool	9.1	11.5	5.3	1.2	1.6	0.6
Kindergarten/grade school	0.8	0.4	1.3	75.2	76.2	73.4
Child cares for self	0.0	0.0	0.0	2.7	3.0	2.1
Parent cares for child [1]	8.1	5.0	13.3	3.2	2.1	5.1
Married, husband present:						
Number of children	6,637	4,051	2,586	14,202	8,424	5,778
Percent	100.0	100.0	100.0	100.0	100.0	100.0
Care in child's home	31.3	24.7	41.6	12.8	11.6	14.6
Care in another home	36.5	42.8	26.5	3.6	4.1	2.8
Organized child care facilities	22.3	27.1	14.7	2.8	3.6	1.5
Day/group care center	12.7	15.3	8.6	1.6	2.1	0.8
Nursery school/preschool	9.6	11.8	6.1	1.2	1.5	0.7
Kindergarten/grade school	0.8	0.4	1.4	75.1	75.8	74.1
Child cares for self	0.0	0.0	0.0	2.3	2.8	1.7
Parent cares for child [1]	9.2	5.0	15.8	3.4	2.2	5.3

TABLE 12.—PRIMARY CHILD CARE ARRANGEMENTS OF CHILDREN UNDER 15 WITH AN EMPLOYED MOTHER, BY MARITAL AND EMPLOYMENT STATUS OF THE MOTHER, WINTER 1984–85—Continued

[Numbers in thousands]

Marital status of mother and type of child care arrangement	Mothers with children under 5 years			Mothers with children 5 to 14 years		
	Total	Employed full time	Employed part time	Total	Employed full time	Employed part time
All other marital statuses: [2]						
Number of children	1,531	1,009	522	4,085	3,328	757
Percent	100.0	100.0	100.0	100.0	100.0	100.0
Care in child's home	30.0	23.2	43.1	8.5	8.1	10.0
Care in another home	39.1	39.7	37.9	6.7	5.9	10.3
Organized child care facilities	26.7	31.4	17.6	3.1	3.3	2.6
Day/group care center	19.6	21.3	16.3	1.7	1.5	2.6
Nursery school/preschool	7.1	10.1	1.3	1.4	1.8	0.0
Kindergarten/grade school	0.6	0.5	0.8	75.5	77.3	67.9
Child cares for self	0.0	0.0	0.0	3.8	3.5	5.0
Parent cares for child [1]	3.5	5.0	0.8	2.3	1.9	4.2

[1] Includes women working at home or away from home.

[2] Includes married, husband absent (including separated), widowed, divorced, and never-married women.

Source: "Who's Minding the Kids?, Child Care Arrangements: Winter 1984–85," U.S. Department of Commerce, Bureau of the Census, Series P–70, No. 9, May 1987.

SECONDARY CHILD CARE ARRANGEMENTS

"Secondary child care arrangement" refers to the arrangement used second most frequently during a typical work week. Almost 7 million children, or 26 percent of all children under age 15, use a secondary child care arrangement. Secondary child care arrangements are used by 32 percent of school-age children 5 to 14 years old, but by only 13 percent of children under 5 years. The usage of secondary child care arrangements by school age children of mothers employed full-time is about three times (41 percent) that of children whose mothers are employed part-time (14 percent).

The types of secondary child care arrangements used by school-age children who are in school most of the time their mothers are at work are shown in table 13. The most frequently mentioned secondary care arrangement for older children whose mothers are employed full-time is care in the child's own home (41 percent). Another 24 percent are cared for in someone else's home, while about 8 percent attend day/group care centers after school. Twenty-one percent care for themselves.

TABLE 13.—SECONDARY CHILD CARE ARRANGEMENTS FOR CHILDREN 5 TO 14 WHO ARE IN SCHOOL MOST OF THE TIME WHILE THEIR MOTHERS ARE AT WORK, WINTER 1984–85

[Numbers in thousands]

Type of child care arrangement	Total		Employed full time		Employed part time	
	Number	Percent	Number	Percent	Number	Percent
Number of children	5,037	100.0	4,320	100.0	716	100.0
Care in child's home	2,094	41.6	1,797	41.6	296	41.3
Care in another home	1,258	25.0	1,033	23.9	227	31.7
Organized child care facilities	344	6.8	334	7.7	9	1.3
Day/group care center	327	6.5	321	7.4	5	0.7
Nursery school/preschool	17	0.3	13	0.3	4	0.6
Kindergarten/grade school	38	0.8	38	0.9	0	0.0
Child cares for self	1,006	20.0	918	21.3	88	12.3
Parent cares for child[1]	294	5.8	199	4.6	95	13.3

[1] Includes mothers working at home or away from home.

Source: "Who's Minding the Kids?, Child Care Arrangements: Winter 1984–85," U.S. Department of Commerce, Bureau of the Census, Series P–70, No. 9, May 1987.

COST OF CHILD CARE

Table 14 shows that 5.3 million women who were employed in the winter 1984–85, and who had at least one child under 15 years old, paid cash for child care arrangements. The median amount paid for all child care arrangements in 1984–85 was $37.50 per week. If these weekly estimates of child care expenditures derived for winter 1984–85 were assumed to be representative of costs over the entire year, child care arrangements made by working women over the course of a year could exceed $11 billion.

TABLE 14.—PERCENT DISTRIBUTION OF WEEKLY CASH PAYMENTS MADE BY EMPLOYED MOTHERS FOR ALL CHILD CARE ARRANGEMENTS, BY SELECTED CHARACTERISTICS, WINTER 1984-85

[Numbers in thousands]

Characteristic	Total	Not paying cash	Paying cash										
			Number	Total	Under $10	$10 to $19	$20 to $29	$30 to $39	$40 to $49	$50 to $59	$60 to $69	$70 and over	Median (dollars)
Number of women	7,713	2,414	5,299	100	3.8	11.0	20.7	19.4	15.7	12.9	5.9	10.6	37.5
Number of children:													
1 child	3,746	1,303	2,443	100	3.5	11.0	24.5	21.7	17.2	12.7	4.8	4.7	35.1
2 children	3,041	822	2,219	100	3.8	9.3	17.4	18.7	14.8	13.3	7.7	15.0	40.5
3 or more children	926	289	638	100	5.2	17.1	17.6	12.6	12.8	12.5	4.5	17.7	38.0
Age of youngest child:													
Less than 1 year old	983	337	646	100	1.2	10.6	15.6	20.4	14.2	20.3	3.4	14.4	41.6
1 year old	1,157	316	841	100	3.1	4.6	19.3	16.1	19.3	11.0	9.3	17.3	43.6
2 years old	1,140	273	867	100	2.6	7.8	18.9	18.8	14.7	18.6	6.1	12.5	41.4
3 years old	1,111	293	818	100	3.9	6.3	14.4	21.4	22.8	15.0	5.9	10.3	41.8
4 years old	963	254	709	100	3.1	12.8	22.3	19.3	15.1	11.7	5.0	10.7	36.1
5 to 11 years old	2,170	793	1,377	100	6.8	18.9	26.0	20.7	11.3	6.9	5.7	3.7	29.4
12 to 14 years old	189	147	42	100	NA	NA	NA	NA	NA	NA	NA	NA	NA

TABLE 14.—PERCENT DISTRIBUTION OF WEEKLY CASH PAYMENTS MADE BY EMPLOYED MOTHERS FOR ALL CHILD CARE ARRANGEMENTS, BY SELECTED CHARACTERISTICS, WINTER 1984-85—Continued

[Numbers in thousands]

Characteristic	Total	Not paying cash	Paying cash										
			Number	Total	Under $10	$10 to $19	$20 to $29	$30 to $39	$40 to $49	$50 to $59	$60 to $69	$70 and over	Median (dollars)
Employment status:													
Full time	5,686	1,597	4,089	100	2.2	8.3	18.7	20.1	16.8	15.4	7.1	11.4	40.5
Part time	2,027	817	1,210	100	9.4	20.3	27.3	17.0	12.1	4.5	2.2	7.2	27.5
Marital status:													
Married, husband present	5,495	1,549	3,946	100	3.9	9.8	19.4	19.2	15.6	14.5	5.9	11.5	38.8
All other marital statuses[1]	2,218	865	1,353	100	3.6	14.4	24.5	19.7	15.9	8.2	6.1	7.5	33.8

[1] Includes married, husband absent (including separated), widowed, divorced, and never married women.

Note: Median cash payments derived from more detailed distribution of dollar amounts.

NA: Not available due to small sample size.

Source: "Who's Minding the Kids? Child Care Arrangements: Winter 1984–85," U.S. Department of Commerce, Bureau of the Census, Series P–70, No. 9, May 1987.

EMPLOYER CHILD CARE PRACTICES [7]

As table 15 indicates, about 2 percent, or 25,000, of the Nation's establishments (both private industry and government) with 10 employees or more sponsor day care centers for their workers' children. Three percent, or 35,000 establishments, provide financial assistance to be used specifically for child care. Overall, 11 percent of these establishments, provide some specific benefits or services to workers for their child care arrangements. In addition to sponsoring centers or providing financial assistance, these services include counseling, referral, and the provision of information about local child care.

Child care practices vary with the size of the establishment. As table 15 shows, among those establishments with 250 employees or more, about 5 percent actually sponsor day care centers and 9 percent assist their employees with child care expenses. Much smaller proportions of medium-sized firms (50 to 249 employees) and small-sized firms (10 to 49 employees) provide such benefits. Altogether, 32 percent of the largest establishments, compared with only 9 percent of the smallest, provide some child care benefits or services.

As table 15 also indicates, government agencies are much more likely than firms in private industry to sponsor child care, even if one controls for the size of the establishment. Overall, about 9 percent of government offices (including Federal, State, and local agencies) actually sponsor day care centers for their workers' children. Among private firms, the comparable proportion was less than 2 percent. Government agencies are also much more likely to provide their employees with child care information, referral and counseling services. Overall, private firms are equally as likely as government agencies to assist their employees with child care expenses (3.1 percent and 2.9 percent, respectively). However, if one controls for the size of the establishment, medium- and large-sized private firms are roughly twice as likely to assist with child care expenses.

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[7] This and the next subsection borrow heavily from "BLS Reports on Employer Child-Care Practices," Bureau of Labor Statistics, U.S. Department of Labor, USDL 88-7, January 15, 1988.

TABLE 15.—TYPE OF CHILD-CARE BENEFITS PROVIDED BY ESTABLISHMENTS WITH 10 EMPLOYEES OR MORE, BY TYPE AND SIZE OF ESTABLISHMENT, SUMMER 1987

Type of establishment and child care benefits	Establishments with 10 employees or more			
	Total	10 to 49 employees	50 to 249 employees	250 employees or more
Total establishments (thousands)	1,202	919	236	47
Percent providing child-care benefits or services	11.1	9.0	15.3	31.8
Employer-sponsored day care	2.1	1.9	2.2	5.2
Assisted with child-care expenses	3.1	2.4	4.7	8.9
Child-care information and referral services	5.1	4.3	6.3	14.0
Counseling services	5.1	3.8	7.6	17.1
Other child-care benefits	1.0	.7	1.6	2.9
Private sector establishments (thousands)	1,128	879	213	36
Percent providing child-care benefits or services	10.1	8.3	14.1	31.6
Employer-sponsored day care	1.6	1.5	1.8	2.7
Assisted with child-care expenses	3.1	2.4	4.9	10.3
Child-care information and referral services	4.3	3.6	5.5	14.6
Counseling services	4.2	3.1	6.5	17.0
Other child-care benefits	.9	.7	1.5	2.7
Government establishments (thousands)	74	40	23	11
Percent providing child-care benefits or services	26.4	24.1	27.2	32.7
Employer-sponsored day care	9.4	10.2	6.1	13.2
Assisted with child-care expenses	2.9	2.5	2.8	4.3
Child-care information and referral services	15.8	17.9	14.1	12.0
Counseling services	18.2	18.6	17.9	17.4
Other child-care benefits	2.3	1.5	2.9	3.7

EMPLOYER WORK-SCHEDULE POLICIES

In addition to child care services, employers can establish work policies to help parents care for their children, including flexitime, voluntary part-time, and flexible leave policies.[8] As table 16 indicates, about three-fifths of all establishments with 10 employees or more, whether private or government, report work policies that can aid parents in caring for their children. Among the establishments with work-schedule policies, 4 out of 10 employers have flexitime; 4 out of 10 also report flexible leave policies. About one-third report voluntary part-time arrangements. Smaller establishments are more likely to provide these policies than large establishments.

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[8] "Flexitime" is a plan by which employees may vary the times their workdays begin and end. "Voluntary part-time" is a system which allows a full-time employee to work fewer hours (with reduced pay and benefits) on a temporary basis. "Flexible leave" includes personal leave to care for short-term needs, extension of maternity or paternity leave, or parental leave. Other leave categories such as annual or sick leave are not included unless they are flexibly administered.

TABLE 16.—WORK-SCHEDULE POLICIES OF PRIVATE AND GOVERNMENT ESTABLISHMENTS WITH 10 EMPLOYEES OR MORE, BY SIZE OF ESTABLISHMENT, SUMMER 1987

[Percent of establishments]

Work-schedule policies	Total	Size of establishment		
		10 to 49 employees	50 to 249 employees	250 employees or more
Private industry:				
Percent with work-schedule policies aiding child care	61.4	62.2	58.6	58.5
Flexitime	43.6	45.3	38.3	34.7
Voluntary part time	35.3	36.3	32.9	26.2
Job sharing	15.0	15.6	12.7	13.5
Work at home	8.5	9.4	5.7	4.0
Flexible leave	42.9	43.7	39.9	39.6
Other leave or work-schedule policies	1.8	1.6	2.5	3.0
Government:				
Percent with work-schedule policies aiding child care	57.2	57.9	53.7	62.0
Flexitime	37.5	41.1	32.1	35.5
Voluntary part time	26.7	29.8	23.5	21.7
Job sharing	23.5	24.4	22.4	22.6
Work at home	4.0	4.2	4.1	3.4
Flexible leave	43.7	46.2	39.9	42.2
Other leave or work-schedule policies	7.1	8.4	6.8	3.3

Source: U.S. Department of Labor, Bureau of Labor Statistics, USDL 88–7, January 1988.

Note: The individual categories will sum to more than the total because many employees provide more than one policy.

THE FEDERAL ROLE [9]

This subsection focuses on the role of the Federal Government in the child care area, other than its role as a provider of child care services to employees of Federal Government agencies.

There is no comprehensive Federal policy directing the provision or funding of child care services. Rather, the role of the Federal Government in this area is primarily to provide funding for day care through a variety of programs, most of which also fund other services. Unfortunately, child care participation and funding data for these programs are limited.

The child and dependent care tax credit provides indirect support in the form of an income tax credit, primarily to those who work or are seeking work, for a portion of child care expenses. The estimated revenue loss for this tax credit in 1985 was $3.1 billion for 8.4 billion claims. See part 1, section 12, for a more complete description of this tax credit.

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[9] This section borrows heavily from "Child Day Care: Issues and Legislation in the 100th Congress" a study prepared by Sharon Stephan, Education and Public Welfare Division, Congressional Research Service, September 1987; and "Federal Programs Affecting Childen, 1987," a study prepared by the Select Committee on Children, Youth, and Families, July 1987.

The Social Services Block Grant Program is authorized under title XX of the Social Security Act and provides grants to States for activities determined by the States to be appropriate social services. Typical activities include child care. The fiscal year 1987 appropriation for all title XX services was $2.7 billion. See section 10 of part 1 for a more complete description of this program.

The Head Start Program provides Federal matching funds for programs to help improve the social and learning skills and the nutrition and health status of low-income children. The fiscal year 1987 appropriation for Head Start was $1.1 billion, to serve an estimated 452,000 children.

The Child Care Food Program, authorized under the National School Lunch Act, provides funds to reimburse participating child care centers and family and group day care homes for the cost of providing meals and snacks for children. The fiscal year 1987 appropriation for this program was $537.2 million, to serve an estimated 1.1 million children daily.

The Work Incentive (WIN) Program, Community Work Experience Program (CWEP) and Job Search Program are all authorized under title IV of the Social Security Act and allow States to establish employment and training programs for recipients of AFDC. In addition to other employment and training services, WIN may fund child care, and/or train AFDC workers as child care workers. WIN is jointly administered at the Federal level by the Departments of Labor and Health and Human Services, and at the State level by the State employment and welfare agencies. At their discretion, States may also operate the CWEP program, which requires AFDC recipients to work off their AFDC benefits. In addition to reimbursing recipients for child care expenses, States may require AFDC recipients to work in child care facilities. Fifty percent matching funds are available for the costs of recipient child care. States are also authorized to require certain AFDC recipients and applicants to participate in job search programs administered through the State welfare agency. Participants in job search programs must be furnished child care, or must be paid amounts to cover day care expenses which enable them to participate. See section 7 for a more complete description of these programs.

Other Federal support for child care includes support for services through the community services block grant program under the Human Services Reauthorization Act of 1986, the community development block grant program under the Housing and Community Development Act; the dependent care planning and development program under the Human Services Reauthorization Act of 1986, employer-provided child or dependent care services under the Internal Revenue Code; the Indian child welfare program under the Indian Child Welfare Act; the dislocated workers program under the Job Training Partnership Act; the Area Economic and Human Resource Development Program under the Appalachian Regional Development Act; and the Food Stamp Program under the Food Stamp Act.

Additional Federal support is also provided through a variety of programs to enhance the nutrition of children in child care; provide incentives to businesses to provide day care benefits; provide for the training of child care workers; and provide preschool services for handicapped children. In addition, at State or local discretion, a portion of grants received under a number of Federal elementary and secondary education programs could be used for prekindergarten services for children.

INCOME SOURCES OF FAMILIES WITH CHILDREN [10]

FEMALE-HEADED FAMILIES WITH CHILDREN

Tables 17 through 20 present data on the income sources which families with children relied upon for economic support in 1986. Tables 17 and 18 describe sources for female-headed families with no husband present; tables 19 and 20 describe the sources of income upon which male-present families rely.

Table 17 shows that the percent of female-headed families receiving income from earnings (wages, salaries, self-employment and farm income), alimony or child support, interest and dividends, and Social Security tends to increase as total income increases above the poverty threshold. In turn, families below the poverty threshold are more likely to receive public cash assistance, presumably AFDC, and food stamps—a form of near-cash assistance.

Nearly half (48 percent) of all poor female-headed families with children had income from earnings. As table 18 shows, on average earnings accounted for about 34 cents of every dollar of income received. Sixty-nine percent of poor families between 75 and 100 percent of poverty had income from earnings; for these families, earnings accounted for roughly half of total income. In contrast, 96 percent of nonpoor female-headed families had earnings which on average accounted for 80 percent of total income.

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[10] Please see Appendix H for similar income source data related specifically to the elderly. See Appendix I for data on trends in income and income inequality for families with children and other families.

TABLE 17.—PERCENT OF FEMALE-HEADED FAMILIES WITH CHILDREN WITH INCOME FROM VARIOUS SOURCES, BY RATIO OF TOTAL INCOME TO POVERTY THRESHOLD,[1] 1986

	Ratio of total income to poverty threshold								Poor	Nonpoor	Total
	Under 0.50	0.50 to 0.74	0.75 to 0.99	1.00 to 1.24	1.25 to 1.49	1.50 to 1.99	2.00 to 2.99	3.00 and over			
Number of families (in thousands)	1,707	1,050	756	574	429	870	1,181	930	3,513	3,984	7,497
Earnings	37.8	50.3	68.7	85.1	94.7	96.8	98.6	98.4	48.2	95.8	73.5
OASDI, railroad retirement	5.1	11.1	22.1	16.9	14.0	14.1	19.1	16.7	10.6	16.6	13.8
Pensions	.3	1.2	2.3	1.3	2.5	4.0	5.1	6.0	1.0	4.3	2.7
Unemployment compensation, workers compensation, veterans payments	3.2	4.8	11.5	12.6	13.8	12.3	11.0	8.0	5.5	11.1	8.5
AFDC, SSI, general assistance	64.4	73.2	46.6	29.9	23.8	12.3	7.1	2.7	63.2	12.3	36.1
Child support, alimony	19.7	29.9	32.5	36.4	39.3	43.0	50.4	53.6	25.5	46.3	36.6
Interest, dividends	6.1	10.0	19.8	21.7	33.1	41.3	58.7	78.1	10.2	51.3	32.0
Food Stamps	71.6	72.8	50.6	33.4	18.8	9.5	5.0	.4	67.4	10.5	37.2
Housing assistance	32.9	28.6	23.8	17.0	18.1	9.5	4.6	1.2	29.6	8.1	18.2
Family characteristics:											
Percent never-married	39.5	30.1	24.2	21.1	24.5	18.8	12.6	6.8	33.4	15.1	23.7
Percent with head age 15 to 19	3.6	1.4	2.0	.6	.9	([3])	.2	.3	2.6	.3	1.4
Percent with head age 20 to 29	42.2	38.6	29.0	27.1	22.3	24.7	15.1	6.0	38.3	17.6	27.3
Percent with head 30 and over	54.2	60.0	69.0	72.3	76.8	75.3	84.7	93.7	59.1	82.1	71.3
Percent white non-Hispanic [2]	39.8	46.4	56.3	51.9	55.4	61.6	70.8	77.2	45.3	65.9	56.3
Percent black non-Hispanic	46.9	35.9	30.8	33.4	34.3	28.1	22.1	18.4	40.1	25.5	32.4
Percent Hispanic	13.3	17.7	12.9	14.7	10.3	10.2	7.1	4.5	14.5	8.6	11.4

[1] Based on census ("Orshansky") poverty levels.

[2] Includes "other races."

[3] Less than .05

Source: March 1987 Current Population Survey (CPS). Table prepared by CRS.

TABLE 18.—PERCENT OF TOTAL FAMILY INCOME FROM VARIOUS SOURCES, BY RATIO OF TOTAL INCOME TO POVERTY THRESHOLD FOR FEMALE-HEADED FAMILIES WITH CHILDREN, 1986 [1]

	Ratio of total income to poverty threshold								Poor	Nonpoor	Total
	Under 0.50	0.50 to 0.74	0.75 to 0.99	1.00 to 1.24	1.25 to 1.49	1.50 to 1.99	2.00 to 2.99	3.00 and over			
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Earnings	22.9	28.8	48.3	68.7	75.6	80.4	81.2	81.7	34.1	80.0	72.3
OASDI, railroad retirement	4.4	7.5	11.9	8.5	7.1	5.6	5.4	2.8	8.2	4.7	5.3
Pensions	.1	.5	.7	.3	.3	.9	1.6	1.1	.5	1.1	1.0
Unemployment compensation, workers compensation, veterans payments	1.2	1.5	2.5	2.3	2.0	1.5	1.4	.3	1.8	1.1	1.2
AFDC, SSI, general assistance	62.4	54.7	28.4	12.2	7.1	2.6	1.1	.2	47.5	2.2	9.8
Child support, alimony	8.6	6.7	7.4	7.2	7.0	7.5	7.0	6.8	7.5	7.0	7.1
Interest, dividends	.3	.4	.7	.9	1.0	1.5	2.3	6.9	.5	3.8	3.3
Food stamps [2]	(47.3)	(17.7)	(6.1)	(2.7)	(1.1)	(.3)	(.2)	(.0)	(21.9)	(.4)	(4.0)
House assistance [2]	(19.4)	(9.5)	(5.3)	(2.4)	(1.8)	(.7)	(.3)	(.0)	(10.8)	(.5)	(2.2)
Mean income per family member	$826	$1,840	$2,547	$3,316	$4,117	$5,343	$7,498	$13,028	$1,485	$7,255	$4,411
Mean family size	3.5	3.3	3.3	3.2	3.1	3.0	3.0	2.9	3.4	3.0	3.2
Percent with 50 percent or more of family income from cash public assistance	54.8	52.9	23.1	5.6	1.5	0.2			47.4	1.0	22.8
Percent with 90 percent or more of family income from cash public assistance	41.5	34.7	11.5	1.8	0.4				33.0	0.3	15.6

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[1] Based on census ("Orshansky") poverty levels.

[2] The cash value of food stamps and housing assistance were estimated using their market values. Their cash values are excluded from total income for purposes of determining poverty status as well as for calculating the percentage of total income. The numbers in this row for food stamps and housing assistance represent the added percentage contribution to total cash income.

Source: March 1987 Current Population Survey (CPS). Table prepared by CRS.

It is interesting to note that nonpoor female-headed families were almost twice as likely as poor female-headed families to receive child support or alimony—46 percent compared to 25 percent. For both poor and nonpoor female-headed families, child support on average accounted for roughly 7 percent of total income.

Cash public assistance, mostly AFDC, was the most common source of cash income received by poor female-headed families with children. Approximately 63 percent of these families received cash public assistance which, on average, accounted for about 48 cents of every dollar received.

Food stamps, although not cash income, were an important source of income to poor female-headed families.[11] Nearly 70 percent received food stamps at some time during the year. For each dollar of cash income received, food stamps, on average, provided an additional 22 cents.

MALE-PRESENT FAMILIES WITH CHILDREN

Among male-present families (mostly married couple families) with children who were poor, earnings were on average the most common source and the largest component of total income (see tables 19 and 20). Some 80 percent of all such families had income from earnings, which accounted for 69 cents of every dollar received. Seventeen percent of poor male-present families received income from either unemployment compensation, workers' compensation, or veterans' payments, and these sources accounted for 5 cents of every dollar received. Twenty-seven percent of poor families headed by a male received cash public assistance, which, on average, accounted for 15 cents of each dollar these families received.

Poor male-present families were much less likely than female-headed families to receive food stamps. Only 42 percent of poor male-present families received food stamps, compared with 67 percent of female-headed families.

In 1982 and 1983, 32.5 percent of all poor children in married-couple families, and 5.5 percent of all poor children in female-headed families, had a parent who worked full-time year round. This means that an estimated 2.5 million children were poor (more than 2.1 million in married-couple families) despite a parent's earnings from more than 2,000 hours of work.

The share of poor married-couple families with at least one full-time working parent was 34.7 percent for whites and 22.7 percent for blacks. The share of poor mother-child families with a full-time working mother was 5.1 percent for whites and 6 percent for blacks.

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[11] The cash value of food stamps was not included as part of total income for purposes of determining poverty status, or in the base for calculating the percentage share of total income.

TABLE 19.—PERCENT OF MALE-PRESENT FAMILIES WITH CHILDREN WITH INCOME FROM VARIOUS SOURCES, BY THE RATIO OF TOTAL INCOME TO THE POVERTY THRESHOLD,[1] 1986

	Ratio of total income to poverty threshold								Poor	Nonpoor	Total
	Under 0.50	0.50 to 0.74	075 to 0.99	1.00 to 1.24	1.25 to 1.49	1.50 to 1.99	2.00 to 2.99	3.00 and over			
Number of families (in thousands)	707	672	902	1,034	1,217	2,721	6,107	13,409	2,281	24,489	26,770
Earnings	65.6	84.1	91.6	95.0	97.8	98.6	99.4	99.8	81.3	99.3	97.7
OASDI, railroad retirement	6.7	10.2	14.5	11.0	7.8	6.6	5.3	4.0	10.8	5.1	5.6
Pensions	.8	1.6	2.4	2.9	4.0	3.5	4.0	4.8	1.7	4.4	4.1
Unemployment compensation, workers compensation, veterans payments	11.1	16.2	21.5	23.3	24.8	20.4	18.9	12.0	16.7	15.8	15.8
AFDC, SSI, general assistance	26.1	35.7	21.3	11.7	7.7	6.2	2.1	.8	27.1	2.5	4.6
Child support, alimony	8.2	11.9	12.2	13.3	11.1	11.4	12.8	13.0	10.9	12.7	12.6
Interest, dividends	21.5	19.3	26.4	31.3	36.9	48.2	65.0	83.1	22.8	70.2	66.2
Food stamps	43.0	51.5	34.7	19.9	12.7	6.4	1.4	.2	42.2	2.6	6.0
Housing assistance	9.2	9.1	5.8	4.1	4.7	1.9	.8	.2	7.8	.9	1.5
Family characteristics:											
Percent with head age 15 to 19	3.7	.4	.5	.6	1.0	.4	.1	.0	1.5	.1	.3
Percent with head age 20 to 29	24.8	27.6	27.5	26.7	26.5	26.7	19.3	10.9	26.7	16.2	17.1
Percent with head age 30 and over	71.5	72.0	71.9	72.7	72.5	72.9	80.6	89.1	71.8	83.7	82.7
Percent white non-Hispanic[2]	66.1	65.8	65.7	64.0	69.6	77.0	82.6	89.1	65.9	84.1	82.6
Percent black non-Hispanic	14.4	12.6	13.6	16.4	13.6	11.1	9.8	6.3	13.5	8.5	8.9
Percent Hispanic	19.5	21.6	20.7	19.6	16.8	11.9	7.6	4.6	20.6	7.4	8.5

[1] Based on census ("Orshansky") poverty levels.

[2] Includes "other" races.

Source: March 1987 Current Population Survey (CPS). Table prepared by CRS.

TABLE 20.—PERCENT OF TOTAL FAMILY INCOME FROM VARIOUS SOURCES, BY THE RATIO OF TOTAL INCOME TO THE POVERTY THRESHOLD,[1] FOR MALE-PRESENT FAMILIES WITH CHILDREN: 1986

	Ratio of total income to poverty threshold								Poor	Nonpoor	Total
	Under 0.50	0.50 to 0.74	0.75 to 0.99	1.00 to 1.24	1.25 to 1.49	1.50 to 1.99	2.00 to 2.99	3.00 and over			
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Earnings	57.6	64.1	75.1	83.3	88.1	91.3	93.7	93.6	69.4	93.2	92.8
OASDI, railroad retirement	7.0	6.1	8.6	5.1	3.5	2.2	1.3	.5	7.6	.8	1.0
Pensions	.3	.7	.7	1.2	1.4	1.1	.9	.8	.6	.9	.9
Unemployment compensation, workers compensation, veterans payments	4.6	4.4	4.8	4.4	3.6	2.2	1.6	.6	4.6	1.0	1.1
AFDC, SSI, general assistance	26.2	22.3	8.2	3.4	1.5	1.1	.2	.0	15.0	.2	.5
Child support, alimony	2.6	1.9	1.6	1.8	1.3	1.0	.8	.5	1.8	.6	.7
Interest, dividends	1.8	.6	1.0	.8	.7	1.2	1.6	3.9	1.0	3.2	3.2
Food stamps [2]	(27.7)	(10.5)	(3.7)	(1.4)	(.7)	(.2)	(.0)	(.0)	(9.0)	(.1)	(.2)
Subsidized housing	(5.4)	(1.9)	(.8)	(.5)	(.3)	(.1)	(.0)	(.0)	(1.8)	(.0)	(.1)
Mean income per family member	606	1,667	2,326	3,027	3,696	4,761	6,837	14,009	1,609	10,004	9,215
Mean family size	4.4	4.7	4.6	4.5	4.4	4.3	4.2	3.9	4.6	4.1	4.1

[1] Based on census ("Orshansky") poverty levels.

[2] The cash value of food stamps and housing assistance were estimated using their market values. Their cash values are excluded from total income for purposes of determining poverty status as well as for calculating the percentage share of total income. The numbers in this row for food stamps and housing assistance represent the added percentage contribution to total cash income.

Source: March 1987 Current Population Survey (CPS). Table prepared by CRS.

FEDERAL TAX TREATMENT OF FAMILIES IN POVERTY

LEGISLATION BEFORE 1986

In the past two decades, Congress has attempted to ensure that families in poverty do not pay Federal income taxes. These legislative efforts reflect the policy that in a progressive income tax system a family should not be liable for income tax until income exceeds the poverty threshold (as measured by the standards set by the U.S. Bureau of the Census). Tax bills enacted in 1969, 1975, 1977, and 1978 all reflect this Congressional policy.

Before 1975, the principal tools used to eliminate the Federal income tax liability of families in poverty were the standard deduction (during the years 1978 to 1986, termed the zero bracket amount) and the personal exemption. The standard deduction is a statutorily set amount of income which the taxpayer may receive with no tax liability. The personal exemption is an additional deduction "provided" for the taxpayer, the taxpayer's spouse, and each dependent. The total tax benefit of the personal exemption is thus contingent on the number of persons in the taxpayer's family.

In 1975, the Congress enacted the earned income tax credit. The credit is refundable, thus reflecting two Congressional goals: one, to remove poor families from the income tax rolls, and two, through its cash refund feature, to offset a portion of the Social Security payroll tax on the earnings of working poor families. The earned income tax credit is available only to households with dependents, and thus is explicitly designed to help low income families, rather than single individuals or married couples with no dependents. The earned income tax credit is described more fully in section 12.

Before 1985, neither the standard deduction nor the personal exemption was indexed to changes in the price level, and as a result inflation eroded the value of these tax benefits to poor households. In part to correct for this erosion of the value of the personal exemption and the standard deduction, Congress significantly reduced the taxes of the poor and enacted the earned income tax credit in 1975. Because inflation continued to erode the value of these benefits, however, the income taxes of the poor commenced to increase again after that year. Tax cut bills enacted in 1976, 1977, and 1978 abated this trend, but did not halt it. In 1985, the personal exemption and standard deduction became indexed for inflation, but by that year, despite the legislation of earlier years, the poor incurred positive tax liabilities at income levels as low, when measured in real terms, as the levels that held in 1974 before the enactment of the EITC and other tax reductions in 1975. Furthermore, because the earned income credit was not indexed, the tax burdens of families in poverty were slated to rise throughout the 1980's in the absence of offsetting legislation.

In short, the trend from the 1970's until 1986, was that inflation gradually increased the tax burdens of the poor and lowered the income level at which a poor family became liable for income tax. Legislation enacted by Congress reversed or slowed this trend, but in the absence of indexing, inflation gradually offset these legislative efforts. This trend can be measured in two ways: one measure is the degree to which the income at which a poor family begins to pay income taxes (termed the tax threshold, or alternatively, the tax entry point) exceeds or falls below that family's poverty threshold. A second measure is the actual amount of tax liability incurred by a family with income at the poverty line.

Table 21 shows the income tax threshold, the poverty level, and the tax threshold as a percent of the poverty level for a married couple with two children in selected years since 1959. These figures demonstrate that before 1974 a family of four was generally liable for Federal income tax, even though the family's income was significantly below the poverty line. In 1975, following the enactment of the earned income credit, a family of four incurred no tax liability until its income exceeded the poverty threshold by 22 percent. Over the next decade this margin eroded; by 1984, a poor family of four incurred tax liability when its income was 17 percent *below* the poverty line.

Table 22 shows the income tax burden and payroll tax burden of households with incomes below the poverty line given different family sizes. This table shows that a family of four in 1978 had an income tax refund (through the earned income tax credit) of $134; this refund offset 33 percent of the family's payroll tax burden of $403. By 1986, this same family incurred a positive tax liability of $363. Combined income and payroll taxes represented 4 percent of this family's income in 1978; by 1986, combined income and payroll taxes consumed 10.4 percent of this family's income.

THE TAX REFORM ACT OF 1986

The Tax Reform Act of 1986 significantly altered the structure of taxes affecting the poor. As a result, poor families with children or other dependents will incur no Federal income tax liability in 1987 or thereafter, and will face a greatly reduced combined Federal income and payroll tax burden. Because the system as enacted is indexed to inflation, future increases in the Consumer Price Index will not erode these tax benefits.

The Tax Reform Act greatly expanded the level of the personal exemption for each dependent from its level of $1,080 in 1986, to $1,900 in 1987, $1,950 in 1988, and $2,000 in 1989. The standard deduction was increased to $5,000 for a married couple filing jointly and $4,400 for an unmarried head of household effective 1988. The maximum value of the earned income credit was increased, and the credit was made available to a greater number of low income families. The personal exemption is indexed after 1989, the standard deduction is indexed after 1988, and the earned income tax credit is indexed immediately.

As a result of this legislation, in 1988 a married couple with two children (i.e., a family of four) will incur no positive income tax liability until income equals $15,116. This income exceeds the poverty level for a family of four in that year by 25 percent. In 1988, a family of four with income at the poverty level will receive a net income tax refund (through the earned income tax credit) of $646; this offsets this family's payroll tax burden in that year of $911 by 71 percent.

TABLE 21.—RELATIONSHIP BETWEEN INCOME TAX THRESHOLD AND POVERTY LEVEL FOR A FAMILY OF FOUR, 1959–1990

Year	Income tax threshold	Poverty level	Tax threshold as a percent of poverty level
1959	$2,667	$2,973	89.7
1960	2,667	3,022	88.3
1965	3,000	3,223	93.1
1966	3,000	3,317	90.4
1968	3,000	3,553	84.4
1969	3,000	3,743	80.2
1970	3,600	3,968	90.7
1971	3,750	4,137	90.6
1972	4,300	4,275	100.6
1973	4,300	4,540	94.7
1974	4,300	5,038	85.4
1975	6,692	5,500	121.7
1976	6,892	5,815	118.5
1977	7,520	6,191	121.7
1978	7,533	6,662	113.1
1979	8,626	7,412	116.4
1980	8,626	8,414	102.5
1981	8,634	9,287	93.0
1982	8,727	9,862	88.5
1983	8,783	10,178	86.3
1984	8,783	10,610	82.8
1986	9,575	11,203	85.5
1987 [1]	13,288	11,612	114.4
1988 [1]	15,116	12,131	124.6
1989 [1]	15,679	12,728	123.2
1990 [1]	16,332	13,312	122.7

[1] Estimated.

Note: Tax thresholds assume full use of the earned income tax credit. They are based on the schedule for a married nonelderly couple filing jointly.

TABLE 22.—TAX THRESHOLDS, POVERTY LEVELS, AND FEDERAL TAX AMOUNTS FOR DIFFERENT FAMILY SIZES WITH EARNINGS EQUAL TO THE POVERTY LEVEL, 1978–1990

	Family size					
	1	2	3	4	5	6
Poverty levels:						
1978	$3,311	$4,249	$5,201	$6,662	$7,880	$8,891
1982	4,900	6,280	7,690	9,862	11,680	13,210
1983	5,061	6,483	7,938	10,178	12,049	13,630
1984	5,277	6,759	8,276	10,610	12,562	14,211
1986	5,572	7,138	8,737	11,203	13,259	14,986
1987 [3]	5,776	7,399	9,056	11,612	13,744	15,534
1988 [3]	6,034	7,729	9,461	12,131	14,358	16,228
1989 [3]	6,331	8,110	9,927	12,728	15,064	17,026
1990 [3]	6,621	8,482	10,382	13,312	15,755	17,807
Income tax threshold: [1]						
1978	3,200	5,200	6,930	7,520	8,183	9,167
1982	3,300	5,400	8,237	8,727	9,216	9,706
1983–84	3,300	5,400	8,315	8,783	9,251	9,719
1986	3,560	5,830	9,063	9,575	10,086	10,598
1987	4,440	7,560	12,192	13,288	14,283	15,278
1988 [3]	4,950	8,900	13,946	15,116	16,286	17,456
1989 [3]	5,100	9,200	14,479	15,679	16,879	18,079
1990 [3]	5,300	9,550	15,102	16,332	17,562	18,792
Income tax at poverty level: [1]						
1978	16	0	−280	−134	−12	0
1982	202	106	−134	285	417	491
1983	209	118	−89	319	432	509
1984	226	149	−9	364	478	569
1986	230	144	−76	363	480	564
1987 [3]	147	0	−635	−352	−113	54
1988 [3]	163	0	−875	−646	−423	−236
1989 [3]	185	0	−913	−667	−433	−237
1990 [3]	198	0	−958	−704	−452	−246
Payroll tax at poverty level:						
1978	200	257	315	403	477	538
1982	328	421	515	661	783	885
1983	339	435	532	682	808	913
1984 [2]	354	453	555	711	842	953
1986	398	510	625	801	948	1,071
1987 [3]	413	529	648	830	983	1,111
1988 [3]	453	580	711	911	1,078	1,219
1989 [3]	475	609	745	956	1,131	1,279
1990 [3]	506	649	794	1,018	1,205	1,362
Combined income and payroll tax at poverty level:						
1978	216	257	35	269	465	538
1982	530	527	381	946	1,200	1,376

TABLE 22.—TAX THRESHOLDS, POVERTY LEVELS, AND FEDERAL TAX AMOUNTS FOR DIFFERENT FAMILY SIZES WITH EARNINGS EQUAL TO THE POVERTY LEVEL, 1978–1990—Continued

	Family size					
	1	2	3	4	5	6
1983	546	554	443	1,001	1,240	1,422
1984	580	602	546	1,075	1,320	1,521
1986	628	654	549	1,164	1,428	1,635
1987 [3]	560	529	12	479	869	1,164
1988 [3]	616	580	−164	265	655	982
1989 [3]	660	609	−167	289	698	1,042
1990 [3]	705	649	−163	314	753	1,116
Combined tax as percent of income at poverty level:						
1978	6.5	6.1	0.7	4.0	5.9	6.1
1982	10.8	8.4	5.0	9.6	10.3	10.4
1983	10.8	8.6	5.6	9.8	10.3	10.4
1984	11.0	8.9	6.5	10.1	10.5	10.7
1986	11.3	9.2	6.3	10.4	10.8	10.9
1987 [3]	9.7	7.2	.1	4.1	6.3	7.5
1988 [3]	10.2	7.5	−1.7	2.2	4.6	6.1
1989 [3]	10.4	7.5	−1.7	2.3	4.6	6.1
1990 [3]	10.6	7.7	−1.6	2.4	4.8	6.3

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[1] The table reflects assumptions that all family income consists of wages or salaries, that families of two or more include a married couple (rather than an unmarried head of household with one or more dependents), that all family members are under age 65, and that families of three or more persons are eligible for the earned income credit. For families of three or more, the effect of the earned income credit is included. Negative figures in the table reflect refundability of earned income credit.

[2] Effective payroll tax calculated as 6.7 percent for 1984 because in this year employees are allowed a payroll tax credit equal to 0.3 percent of taxable wages.

[3] Estimated.

Combined Impact of AFDC, Food Stamps, and Federal Tax Policy Upon the Income of Female-Headed Families: 1960 to 1988

This section examines the effect of AFDC, food stamps and Federal tax policy on the disposable income of female-headed families. The analysis calculates the weighted-average disposable income (weighted across States by 1980 State populations) available to female-headed families with either two or three children, at various wage levels. Disposable income includes wages, AFDC and food stamp benefits, and Federal taxes (income plus payroll). It does not include the value of health-care benefits. To make comparisons across time, wages are expressed as a given percentage (0, 50, 75, 90, 100, or 125) of the appropriate poverty threshold. Alaska and Hawaii are not included in this analysis, but the District of Columbia is included. Thus, the maximum number of States is 49. At the conclusion of this section is a complete description of the methodology.

Table 23 presents the combined AFDC and food stamp benefit level (in real 1988 dollars) for a female-headed family of four with no wages. This table covers the 28-year period from 1960 through 1987.

In real terms, weighted-average annual AFDC benefits by themselves (not shown) declined 27 percent over the entire 28-year period, from $7,677 to $5,569. Since 1972, real AFDC benefits have declined 31 percent, from $8,057 to $5,569. Looking only at recent years, real AFDC benefits increased between 1984 and 1986, from $5,467 to $5,654, but declined in 1987 to $5,569.

Benefits from the food stamp program, which was created in the late 1960's, have on average offset some of the decline in AFDC benefits relative to inflation. Over the entire 28-year period, the weighted average benefit from AFDC and food stamps grew 4.4 percent in real terms, from $7,677 in 1960 to $8,017 in 1987. Since 1972, however, the average annual combined benefit for this family type has declined by 21 percent, from $10,167 to $8,017. Looking only at recent years, the combined AFDC and food stamp benefit increased between 1984 and 1986, from $7,945 to $8,141, but declined in 1987 to $8,017.

These aggregate numbers hide the fact that the level of benefits and changes in benefits vary dramatically across States. The 5 States with the lowest total AFDC and food stamp benefit in 1987 were: Mississippi ($5,217), Alabama ($5,254), Tennessee ($5,766), Texas ($6,003), and Louisiana ($6,117). The 5 States with the highest total AFDC and food stamp benefit in 1987 were: California ($10,673), Connecticut ($10,217), Vermont ($9,997), Wisconsin ($9,822), and New York ($9,553). Some but not all of the variation in benefit levels across States can be explained by cost-of-living differences.

The benefit level in several States (Alabama, Arkansas, Delaware, Florida, Maine, Mississippi, South Carolina) increased by over 50 percent from 1960 to 1987. In 22 States, total benefits (AFDC only in 1960, and food stamps plus AFDC in 1986) declined from 1960 to 1987. In 12 of these States (Idaho, Illinois, Massachusetts, Montana, New Jersey, New Mexico, New York, North and South Dakota, Ohio, Washington and Wyoming), the decline was over 10 percent.

Table 24 shows average disposable income of a mother and three children (without child care expenses) between 1972 and 1987, at wage levels equal to between 0 and 125 percent of the poverty level. Also included in this table are projections for 1988. As discussed below in the methodology section, these 1988 income projections take into account the changes embodied in the Tax Reform Act of 1986. This table illustrates that families earning 50 percent of the poverty level experienced a 23 percent decline in disposal income between 1972 and 1987. The decline for families earning 75 percent of the poverty level was 22 percent. The decline in disposable income is in part due to the loss of AFDC as an income supplement to wages. In 1972, all States paid AFDC benefits to a family with wages equal to 50 percent of the poverty threshold; by 1987 30 States paid AFDC to such a family.

The significant increases in disposable income for 1987 and 1988, particularly with wages at 75 percent of poverty or more, are due to the Tax Reform Act of 1986. Between 1986 and 1987, the Federal Tax burden was reduced by over $500 for a mother with three children and poverty level earnings ($12,129) (see table 25).

By 1988, when the provisions of the 1986 act will be fully in effect, the Federal tax burden for this family type is projected to be reduced by over $1,000.

Tables 26 and 27 are analogous tables for a mother with two children; tables 28 and 29 also present disposable income calculations for a mother with two children, but child care expenses are included. Table 26 shows that mothers with earnings of $7,094, which are slightly greater than full-time earnings at the minimum wage, have had significant reductions in disposable income from 1976 to 1987 (nearly 21 percent). In 1976, this family's disposable income was greater than the poverty threshold in almost all States when AFDC and food stamp benefits were added to wages. In 1987, this happened in only 13 States. Average tax rates on earnings increased by nearly 27 percent between 1976 and 1987 at an earnings level of $7,094.

The significant feature of table 28 is the percentage of child care reimbursed by the combination of AFDC, food stamp and Federal tax policies. This assumes that child care is not directly reimbursed by title XX or a similar program, but that the day care expenses are taken into account when computing AFDC and food stamp benefits and Federal tax liability. For a mother with earnings at 75 percent of poverty, these policies combined to reimburse 95 percent of day care expenses in 1976. By 1984, the percentage reimbursed had fallen to 46 percent, primarily because the number of States supplementing wages with AFDC had fallen from 49 to 11. In 1987, the percentage reimbursed had increased to 60 percent.

TABLE 23.—COMBINED AFDC AND FOOD STAMP BENEFIT LEVELS FOR A FAMILY OF FOUR WITH NO INCOME

[1988 constant dollars]

	1960	1964	1968	1972	1976	1980	1984	1985	1986	1987	Percent change	
											1960 to 1987	1972 to 1987
Alabama	2,649	3,089	3,646	6,840	7,159	6,030	5,488	5,444	5,392	5,254	98.4	−23.2
Arizona	6,454	6,154	5,489	8,897	8,252	7,193	6,803	6,755	7,361	7,162	11.0	−19.5
Arkansas	3,179	3,261	3,687	7,174	7,246	6,515	5,929	6,217	6,187	6,153	93.6	−14.2
California	10,355	9,874	9,053	11,201	11,434	11,055	10,433	10,612	10,825	10,673	3.1	−4.7
Colorado	7,850	6,505	7,578	10,296	9,629	8,488	8,128	8,034	7,970	7,750	−1.3	−24.7
Connecticut	10,595	10,563	12,576	12,584	11,889	10,014	10,202	10,297	10,407	10,217	−3.6	−18.8
Delaware	4,768	6,843	7,660	8,151	9,822	8,016	7,321	7,256	7,324	7,250	52.1	−11.1
District of Columbia	7,995	7,624	7,537	10,224	10,295	8,464	7,609	7,840	8,034	7,934	−0.8	−22.4
Florida	3,757	3,582	3,482	7,960	7,772	7,023	6,716	6,773	6,860	6,802	81.1	−14.5
Georgia	5,250	5,006	5,120	8,079	7,386	6,575	6,447	6,588	6,897	6,785	29.2	−16.0
Idaho	10,066	9,236	9,749	11,249	10,820	8,682	7,398	7,330	7,279	7,083	−29.6	−37.0
Illinois	9,295	8,605	11,429	11,011	10,347	8,476	7,629	7,710	7,652	7,519	−19.1	−31.7
Indiana	5,298	5,052	6,144	9,414	9,173	8,052	7,129	7,070	7,024	7,101	34.0	−24.6
Iowa	8,332	8,739	9,995	10,319	11,031	9,312	8,118	8,025	8,179	7,952	−4.6	−22.9
Kansas	8,813	8,501	9,708	12,202	11,171	8,961	8,147	8,275	8,352	8,234	−6.6	−32.5
Kentucky	6,068	6,275	7,660	8,604	8,911	7,084	6,457	6,421	6,387	6,223	2.5	−27.7
Louisiana	5,201	4,960	4,752	7,102	7,561	6,817	6,342	6,310	6,278	6,117	17.6	−13.9
Maine	5,298	5,695	5,612	8,532	9,664	8,500	8,402	8,449	8,597	8,531	61.0	−0.0
Maryland	7,272	7,693	7,291	9,295	9,033	8,186	7,911	8,077	8,193	8,115	11.6	−12.7
Massachusetts	10,547	10,159	11,797	12,846	11,539	9,312	8,541	8,822	9,207	9,286	−12.0	−27.7

Michigan (Wayne)	6,743	7,348	10,077	13,132	11,854	10,305	8,330	8,665	8,807	8,975	33.1	—31.7
Minnesota	9,728	9,290	10,896	12,607	11,539	10,123	9,962	9,852	9,752	9,514	—2.2	—24.5
Mississippi	2,408	2,296	2,253	5,856	5,657	5,691	5,117	5,086	5,353	5,217	116.6	—10.9
Missouri	5,298	5,052	5,079	7,626	7,772	7,750	7,052	7,107	7,124	6,960	31.4	—8.7
Montana	9,825	9,955	9,176	9,438	9,208	8,246	8,176	8,090	8,024	7,864	—20.0	—16.7
Nebraska	6,261	5,970	8,193	9,914	9,944	8,718	8,128	8,034	7,970	7,750	23.8	—21.8
Nevada	5,105	5,511	6,472	8,723	9,156	8,040	6,707	7,302	7,251	7,057	38.2	—19.1
New Hampshire	8,573	8,405	10,405	11,535	10,855	8,985	8,214	8,238	8,252	8,812	2.8	—23.6
New Jersey	11,125	11,289	13,600	12,250	11,031	9,251	8,349	8,452	8,379	8,456	—24.0	—31.0
New Mexico	8,958	8,530	7,496	8,786	8,394	7,471	7,100	7,042	6,997	6,846	—23.6	—22.1
New York (NYC)	10,933	11,741	11,388	11,988	12,187	10,002	9,689	9,661	9,838	9,553	—12.6	—20.3
North Carolina	6,405	6,992	5,899	8,318	8,297	6,781	6,217	6,634	6,597	6,548	2.2	—21.3
North Dakota	9,825	10,701	10,282	11,678	11,276	9,178	8,291	8,350	8,279	8,049	—18.1	—31.1
Ohio	8,862	6,545	7,906	9,295	9,243	8,198	7,389	7,478	7,552	7,481	—15.6	—19.5
Oklahoma	7,465	7,486	7,169	9,032	9,769	8,464	7,446	7,376	7,642	7,434	—0.4	—17.7
Oregon	9,440	8,507	9,258	10,891	12,380	9,578	8,867	8,952	8,998	8,909	—5.6	—18.2
Pennsylvania	7,128	7,504	8,725	11,988	11,328	8,852	8,080	8,257	8,388	8,154	14.4	—32.0
Rhode Island	7,898	7,695	10,896	10,796	11,083	8,948	8,398	8,546	8,799	9,404	19.1	—12.9
South Carolina	3,034	3,307	3,810	7,007	6,843	6,151	6,073	6,263	6,333	6,170	103.4	—11.9
South Dakota	8,862	8,285	9,381	11,320	10,628	8,609	7,657	7,580	7,861	7,645	—13.7	—32.5

TABLE 23.—COMBINED AFDC AND FOOD STAMP BENEFIT LEVELS FOR A FAMILY OF FOUR WITH NO INCOME—Continued

[1988 constant dollars]

	1960	1964	1968	1972	1976	1980	1984	1985	1986	1987	Percent change: 1960 to 1987	Percent change: 1972 to 1987
Tennessee	3,853	4,593	4,916	7,674	7,106	6,030	5,708	5,865	5,869	5,766	49.7	−24.9
Texas	4,238	4,501	4,670	8,055	7,246	5,933	5,804	6,004	6,160	6,003	41.7	−25.5
Utah	8,139	8,083	7,578	10,129	10,628	9,433	8,176	8,210	8,143	7,917	−2.7	−21.8
Vermont	6.743	6,430	10,200	12,512	11,434	10,922	10,068	10,176	9,989	9,997	48.3	−20.1
Virginia	7,128	7,463	7,824	10,748	10,242	7,931	7,734	7,942	7,879	7,662	7.5	−28.7
Washington	11,462	9,631	10,978	11,535	11,539	10,728	9,643	9,497	9,625	9,348	−18.4	−19.0
West Virginia	5,298	5,620	6,595	8,008	9,156	7,253	6,486	7,033	6,988	6,802	28.4	−15.1
Wisconsin	10,884	10,368	9,790	11,726	12,222	10,644	10,202	10,037	10,052	9,822	−9.8	−16.2
Wyoming	9,391	9,185	8,193	9,938	9,524	8,355	7,840	7,756	7,697	7,487	−20.3	−24.7
Average	7,348	7,259	7,940	9,887	9,748	8,354	7,715	7,792	7,857	7,750	5.5	−21.6
Weighted average	7,677	7,550	8,149	10,167	9,921	8,557	7,945	8,046	8,141	8,017	4.4	−21.1
AFDC benefits (weighted average)	7,677	7,550	8,149	8,057	7,329	6,171	5,467	5,533	5,654	5,569	−27.5	−30.9

Note: For 1960, 1964, and 1968 this is only AFDC benefits. While some families may have received food stamps, the program was only operational in one-third of the counties. Only 2.2 million individuals participated in the food stamp program during fiscal year 1968.

TABLE 24.—COMPARISON OF AVERAGE DISPOSABLE INCOME AT VARIOUS WAGE LEVELS FOR A MOTHER WITH THREE CHILDREN WITHOUT CHILD CARE EXPENSES: 1972, 1976, 1980, 1984, 1986, 1987, AND 1988 PROJECTED

	Wages (as a percent of poverty threshold)				
	0	50	75	100	125
Wages (1988 dollar equivalent)	0	6,065	9,097	12,129	15,161
Average disposable income:					
1972 (1988 dollar equivalent)	10,167	13,155	14,353	15,487	16,729
1976 (1988 dollar equivalent)	9,921	13,082	14,229	14,943	15,807
1980 (1988 dollar equivalent)	8,557	11,541	12,747	13,365	14,293
1984 (1988 dollar equivalent)	7,945	9,449	10,494	11,857	13,132
1986 (1988 dollar equivalent)	8,141	10,021	10,743	11,954	13,610
1987 (1988 dollar equivalent)	8,017	10,134	11,131	12,391	13,720
1988P (1988 dollar equivalent)	8,076	10,150	11,394	13,095	13,920
Percentage change:					
1972–1987	−21.1	−23.0	−22.4	−20.0	−18.0
1980–1987	−6.3	−12.2	−12.7	−7.3	−4.0
1984–1987	0.9	7.2	6.1	4.5	4.5
1980–1988P	−5.6	−12.1	−10.6	−2.0	−2.6
Number of States which supplement wages with AFDC:					
1972	NA	49	47	42	35
1976	NA	49	46	38	26
1980	NA	46	36	27	13
1984	NA	21	5	0	0
1986	NA	32	8	0	0
1987	NA	30	7	0	0
1988P	NA	29	6	0	0
Number of States with disposable income above poverty:					
1972	7	28	41	49	49
1976	3	35	45	49	49
1980	0	13	31	49	49
1984	0	0	0	0	49
1986	0	1	0	0	49
1987	0	1	1	49	49
1988P	0	1	1	49	49
Average tax rate (in percent):					
1972	NA	51	54	56	57
1976	NA	48	53	59	61
1980	NA	51	54	60	62
1984	NA	75	72	68	66
1987	NA	65	66	64	62

NA: Not applicable.

P: Projected based on current law.

Note: Weighted average across States. Disposable income is wages plus AFDC plus food stamps less Federal taxes.

TABLE 25.—COMPOSITION OF AVERAGE DISPOSABLE INCOME AT VARIOUS WAGE LEVELS FOR A MOTHER WITH THREE CHILDREN WITHOUT CHILD CARE EXPENSES: 1972, 1980, 1984, 1986, 1987, AND 1988 PROJECTED

	Wages (as a percent of poverty threshold)				
	0	50	75	100	125
1972 (in 1988 dollars):					
Wages	0	6,065	9,097	12,129	15,161
AFDC	8,057	6,080	4,605	3,053	1,948
Food stamps	2,110	1,325	1,125	935	817
Federal taxes	0	−315	−474	−630	−1,197
Disposable income	10,167	13,155	14,353	15,487	16,729
1980 (in 1988 dollars):					
Wages	0	6,065	9,097	12,129	15,161
AFDC	6,171	3,513	2,129	1,173	556
Food stamps	2,386	1,729	1,416	948	418
Federal taxes	0	235	105	−885	−1,842
Disposable income	8,557	11,541	12,747	13,365	14,293
1984 (in 1988 dollars):					
Wages	0	6,065	9,097	12,129	15,161
AFDC	5,467	856	95	0	0
Food stamps	2,478	2,363	1,828	1,110	0
Federal taxes	0	166	−526	−1,382	−2,029
Disposable income	7,945	9,449	10,494	11,857	13,132
1986 (in 1988 dollars):					
Wages	0	6,065	9,097	12,129	15,161
AFDC	5,654	1,522	252	0	0
Food stamps	2,487	2,273	1,891	1,240	511
Federal taxes	0	161	−497	−1,415	−2,062
Disposable income	8,141	10,021	10,743	11,954	13,610
1987 (in 1988 dollars):					
Wages	0	6,065	9,097	12,129	15,161
AFDC	5,569	1,421	219	0	0
Food stamps	2,448	2,234	1,815	1,152	424
Federal taxes	0	415	0	−890	−1,865
Disposable income	8,017	10,134	11,131	12,391	13,720
1988P (in 1988 dollars):					
Wages	0	6,065	9,097	12,129	15,161
AFDC	5,541	1,364	206	0	0
Food stamps	2,535	2,328	1,900	1,232	−0
Federal taxes	0	394	191	−266	−1,241
Disposable income	8,076	10,150	11,394	13,095	13,920

P: Projected based on current law.

Note: Weighted average across States. If taxes are positive, this means earned income tax credit. A minus sign coincides with the normal definition of taxes. Federal taxes include both income and payroll taxes.

TABLE 26.—COMPARISON OF AVERAGE DISPOSABLE INCOME AT VARIOUS WAGE LEVELS FOR A MOTHER WITH TWO CHILDREN WITHOUT CHILD CARE EXPENSES: 1976, 1980, 1984, 1986, 1987, AND 1988 PROJECTED

	Wages (as a percent of poverty threshold)					
	0	50	75	90	100	125
Wages (1988 dollar equivalent)	0	4,730	7,094	8,513	9,459	11,824
Average disposable income:						
1976 (1988 dollar equivalent)	8,241	10,823	11,944	12,589	12,834	13,494
1980 (1988 dollar equivalent)	7,094	9,470	10,625	11,142	11,360	11,974
1984 (1988 dollar equivalent)	6,583	7,796	8,763	9,298	9,714	10,788
1986 (1988 dollar equivalent)	6,757	8,395	9,115	9,505	9,856	10,895
1987 (1988 dollar equivalent)	6,659	8,428	9,410	10,021	10,423	11,529
1988P (1988 dollar equivalent)	6,705	8,424	9,399	10,160	10,751	11,936
Percentage change:						
1976 to 1987	−19.2	−22.1	−21.2	−20.4	−18.8	−14.6
1980–1987	−6.1	−11.0	−11.4	−10.1	−8.2	−3.7
1984–1987	1.2	8.1	7.4	7.8	7.3	6.9
1980 to 1988P	−5.5	−11.0	−11.5	−8.8	−5.4	−0.3
Disposable income as a percentage of poverty thresholds:						
1976	87.1	114.4	126.3	133.1	135.7	142.7
1980	75.0	100.1	112.3	117.8	120.1	126.6
1984	69.6	82.4	92.6	98.3	102.7	114.1
1987	70.4	89.1	99.5	105.9	110.2	121.9
Number of States which supplement wages with AFDC:						
1976	NA	49	47	45	44	33
1980	NA	47	42	35	33	20
1984	NA	25	7	1	1	0
1986	NA	38	11	4	1	0
1987	NA	38	13	4	1	0
1988P	NA	38	13	4	0	0
Number of States with disposable income above poverty:						
1976	10	40	47	49	49	49
1980	0	21	36	49	49	49
1984	0	1	1	1	49	49
1986	0	7	8	4	49	49
1987	0	8	11	49	49	49
1988P	0	8	11	49	49	49
Average tax rate (in percent):						
1976	NA	45	48	49	51	56
1984	NA	74	69	68	67	64
1987	NA	63	61	61	60	59

NA: Not applicable.

P: Projected based on current law.

Note: Weighted average across States. Disposable income is wages plus AFDC plus food stamps less Federal taxes.

TABLE 27.—COMPOSITION OF AVERAGE DISPOSABLE INCOME AT VARIOUS WAGE LEVELS FOR A MOTHER WITH TWO CHILDREN WITHOUT CHILD CARE EXPENSES: 1976, 1980, 1984, 1986, 1987, AND 1988 PROJECTED

	Wages (as a percent of poverty threshold)					
	0	50	75	90	100	125
1976 (in 1988 dollars):						
Wages	0	4,730	7,094	8,513	9,459	11,824
AFDC	6,223	4,543	3,428	2,759	2,289	1,482
Food stamps	2,018	1,355	1,128	1,000	919	705
Federal taxes	0	196	294	317	167	−517
Disposable income	8,241	10,823	11,944	12,589	12,834	13,494
1980 (in 1988 dollars):						
Wages	0	4,730	7,094	8,513	9,459	11,824
AFDC	5,174	3,168	2,120	1,625	1,315	721
Foods stamps	1,920	1,390	1,137	928	802	441
Federal taxes	0	183	274	76	−216	−1,011
Disposable income	7,094	9,470	10,625	11,142	11,360	11,974
1984 (in 1988 dollars):						
Wages	0	4,730	7,094	8,513	9,459	11,824
AFDC	4,593	1,007	156	5	2	0
Food stamps	1,990	1,903	1,561	1,256	1,026	443
Federal taxes	0	157	−48	−477	−773	−1,479
Disposable income	6,583	7,796	8,763	9,298	9,714	10,788
1986 (in 1988 dollars):						
Wages	0	4,730	7,094	8,513	9,459	11,824
AFDC	4,751	1,685	446	106	3	0
Food stamps	2,006	1,798	1,593	1,335	1,138	572
Federal taxes	0	183	−18	−449	−744	−1,501
Disposable income	6,757	8,395	9,115	9,505	9,856	10,895
1987 (in 1988 dollars):						
Wages	0	4,730	7,094	8,513	9,459	11,824
AFDC	4,685	1,604	398	89	2	0
Food stamps	1,974	1,771	1,535	1,265	1,064	497
Federal taxes	0	324	382	154	−102	−792
Disposable income	6,659	8,428	9,410	10,021	10,423	11,529
1988P (in 1988 dollars):						
Wages	0	4,730	7,094	8,513	9,459	11,824
AFDC	4,662	1,534	363	81	0	0
Food stamps	2,043	1,854	1,601	1,331	1,128	560
Federal taxes	0	307	341	235	164	−448
Disposable income	6,705	8,424	9,399	10,160	10,751	11,936

P: Projected based on current law.

Note: Weighted average across States. If taxes are positive, this means earned income tax credit. A minus sign coincides with the normal definition of taxes. Federal taxes includes both income and payroll taxes.

TABLE 28.—COMPARISON OF AVERAGE DISPOSABLE INCOME AT VARIOUS WAGE LEVELS FOR A MOTHER WITH TWO CHILDREN WITH CHILD CARE EXPENSES: 1976, 1980, 1984, 1986, 1987, AND 1988 PROJECTED

	Wages (as a percent of poverty threshold)					
	0	50	75	90	100	125
Wages (1988 dollar equivalent)	0	4,730	7,094	8,513	9,459	11,824
Average disposable income:						
1976 (1988 dollar equivalent)	8,241	10,752	11,868	12,455	12,645	13,231
1980 (1988 dollar equivalent)	7,094	9,411	10,316	10,723	10,918	11,423
1984 (1988 dollar equivalent)	6,583	7,549	7,996	8,317	8,692	9,816
1986 (1988 dollar equivalent)	6,757	8,282	8,651	8,893	9,170	10,186
1987 (1988 dollar equivalent)	6,659	8,326	8,841	9,144	9,446	10,694
1988P (1988 dollar equivalent)	6,705	8,321	8,821	9,259	9,673	10,960
Percentage change:						
1976–1987	−19.2	−22.6	−25.5	−26.6	−25.3	−19.2
1980–1987	−6.1	−11.5	−14.3	−14.7	−13.5	−6.4
1984–1987	1.2	10.3	10.6	9.9	8.7	8.9
1980–1988P	−5.5	−11.6	−14.5	−13.7	−11.4	−4.1
Number of States which supplement wages with AFDC:						
1976	NA	49	49	49	48	45
1980	NA	49	49	46	44	34
1984	NA	36	11	9	6	1
1986	NA	44	29	12	7	1
1987	NA	44	27	13	7	0
1988P	NA	44	23	13	7	0
Number of States with disposable income above poverty:						
1976	10	37	46	49	49	49
1980	0	21	34	38	41	49
1984	0	0	0	0	1	49
1986	0	7	9	6	5	49
1987	0	8	12	8	6	49
1988P	0	8	11	11	49	49
Average tax rate (in percent):						
1976	NA	47	49	50	53	58
1984	NA	80	80	80	78	73
1987	NA	65	69	71	71	66
Percentage of childcare reimbursed:						
1976	NA	92	95	92	89	85
1980	NA	94	78	75	74	68
1984	NA	74	46	42	41	44
1986	NA	88	67	64	60	59
1987	NA	89	60	48	44	52
1988P	NA	89	59	47	38	44

NA: Not applicable.

P: Projected based on current law.

Note: Weighted average across States. Disposable income is wages plus AFDC plus food stamps less day care expenses less Federal taxes.

TABLE 29.—COMPOSITION OF AVERAGE DISPOSABLE INCOME AT VARIOUS WAGE LEVELS FOR A MOTHER WITH TWO CHILDREN WITH CHILD CARE EXPENSES: 1976, 1980, 1984, 1987, AND 1988 PROJECTED

	Wages (as a percent of poverty threshold)					
	0	50	75	90	100	125
1976 (in 1988 dollars):						
Wages	0	4,730	7,094	8,513	9,459	11,824
AFDC	6,223	5,388	4,740	4,270	3,753	2,527
Food stamps	2,018	1,385	1,159	1,057	996	816
Child care	0	−946	−1,419	−1,703	−1,732	−1,732
Federal taxes	0	196	294	317	167	−206
Disposable income	8,241	10,752	11,868	12,455	12,645	13,231
1980 (in 1988 dollars):						
Wages	0	4,730	7,094	8,513	9,459	11,824
AFDC	5,174	4,101	3,387	2,914	2,428	1,529
Food stamps	1,920	1,343	980	800	721	465
Child care	0	−946	−1,419	−1,703	−1,732	−1,732
Federal taxes	0	183	274	199	39	−666
Disposable income	7,094	9,411	10,316	10,723	10,918	11,423
1984 (in 1988 dollars):						
Wages	0	4,730	7,094	8,513	9,459	11,824
AFDC	4,593	1,630	540	267	100	1
Food stamps	1,990	1,979	1,715	1,445	1,253	700
Child care	0	−946	−1,419	−1,703	−1,732	−1,732
Federal taxes	0	157	66	−206	−389	−977
Disposable income	6,583	7,549	7,996	8,317	8,692	9,816
1987 (in 1988 dollars):						
Wages	0	4,730	7,094	8,513	9,459	11,824
AFDC	4,685	2,404	978	495	205	0
Food stamps	1,974	1,814	1,805	1,685	1,524	1,018
Child care	0	−946	−1,419	−1,703	−1,732	−1,732
Federal taxes	0	324	382	154	−9	−415
Disposable income	6,659	8,326	8,841	9,144	9,446	10,694
1988P (in 1988 dollars):						
Wages	0	4,730	7,094	8,513	9,459	11,824
AFDC	4,662	2,333	921	459	192	0
Food stamps	2,043	1,898	1,884	1,755	1,590	1,080
Child care	0	−946	−1,419	−1,703	−1,732	−1,732
Federal taxes	0	307	341	235	164	−212
Disposable income	6,705	8,321	8,821	9,259	9,673	10,960

P: Projected based on current law.

Note: Weighted average across States. If taxes are positive, this means earned income tax credit. A minus sign coincides with the normal definition of taxes. Federal taxes includes both income and payroll taxes.

STUDY METHODOLOGY

AFDC

Each State's AFDC program was modeled using the appropriate need standard, payment standard, rateable reduction (usually 100 percent), and maximum benefit for July of each year from 1972 to 1987 for families of four, and from 1976 to 1987 for families of three. Data do not exist for three-person families prior to 1976.

All of the AFDC benefit amounts from 1960 to 1968 are from a series of HEW publications entitled: "State Maximums and Other Methods of Limiting Money Payments to Recipients Under Special Types of Public Assistance," September 1960 and October 1968; or "Monthly Cost Standards Used by States for Specified Types of Old Age Assistance Cases and Families Receiving Aid to Families with Dependent Children," January 1961 and January 1965. The AFDC benefit listed in table 23 for 1960 is the January 1961 benefit amount, to which was applied the State maximum AFDC payment amounts in effect for September 1960. Data for 1964 are the January 1965 benefit. The benefit level for 1968 is for the month of April. Data for 1972 to 1987 were provided by the Congressional Research Service. The earlier year data (1960 to 1968) are of lower quality than data for 1972 on. However, the general trends noted in table 28 for 1960 to 1968 are correct.

AFDC benefits are calculated in the fifth month of eligibility, because a majority of female heads with wages are not in their first 4 months of employment. In 1985, 1986, and 1987, the earnings disregard equals $105 per month (under DEFRA, a standard work expense disregard of $75 and a $30 income disregard are applied during the first 12 months of eligibility). In 1984, the disregard equals $75 per month (only the standard deduction is applied after the first 4 months of eligibility under OBRA). For 1972, 1976, and 1980, monthly work expenses of 10 percent of gross wages are applied, up to a maximum of $23, $31, and $45, respectively. The income disregards are applied in 1980 according to the rules in effect prior to enactment of the Omnibus Budget Reconciliation Act (OBRA). Note that work and income disregards are not affected by family size.

The benefit in each State for an AFDC family in its fifth month of eligibility is computed through a four-step process, which is described below. Table 30 presents an example of the calculations for a mother and two children in 1987, with earnings at 50 percent of the poverty threshold.

Step 1: Compute monthly earnings. If monthly earnings are greater than 185 percent of the State need standard, the AFDC benefit equals $0 (zero).

Step 2: Compute monthly countable income. Subtract the monthly total disregard of $105, which includes a standard work expense disregard of $75 plus a $30 income disregard.

Step 3: The AFDC benefit is equal to the State payment standard minus countable income, multiplied by the rateable reduction (which equals 1 in most States), subject to the constraint that the benefit may not exceed the State maximum payment.

Step 4: If the calculated AFDC benefit is less than $10 per month, the actual AFDC benefit equals $0 (zero).

The energy disregard is not used in computing AFDC benefits, but is subtracted from AFDC prior to including AFDC income in the food stamp formula.

TABLE 30.—AFDC BENEFIT FORMULAS FOR EACH STATE, FOR A MOTHER WITH TWO CHILDREN AND MONTHLY EARNINGS OF $377 IN 1987

[1987 dollars]

State	Needs standard	Payment standard	Maximum payment	Rateable reduction	Energy disregard	Monthly AFDC benefit
Alabama	384	118	118	1.0	....	0
Arizona	621	293	293	1.0	....	21
Arkansas	695	202	202	1.0	....	0
California	633	633	633	1.0	....	361
Colorado	421	421	346	.8237	....	123
Connecticut	601	601	601	1.0	....	329
Delaware	310	310	310	1.0	....	38
District of Columbia	712	364	364	1.0	....	92
Florida	775	264	264	1.0	....	0
Georgia	366	263	263	1.0	....	0
Idaho	554	304	304	1.0	....	32
Illinois	689	342	342	1.0	18	70
Indiana	320	288	288	1.0	....	16
Iowa	497	381	381	1.0	....	109
Kansas	409	409	409	1.0	12	137
Kentucky	197	197	197	1.0	....	0
Louisiana	610	190	190	1.0	....	0
Maine	558	558	405	1.0	....	286
Maryland	497	359	359	1.0	59	87
Massachusetts	510	510	510	1.0	....	238
Michigan	630	512	427	1.0	74	240
Minnesota	532	532	532	1.0	....	260
Mississippi	368	368	120	.60	....	57
Missouri	312	282	282	1.0	....	0
Montana	434	359	359	1.0	....	87
Nebraska	350	350	350	1.0	....	78
Nevada	285	285	285	1.0	....	13
New Hampshire	486	486	486	1.0	....	214
New Jersey	424	424	424	1.0	25	152
New Mexico	264	264	264	1.0	....	0
New York	497	497	497	1.0	53	225
North Carolina	518	259	259	1.0	....	0
North Dakota	371	371	371	1.0	....	99

TABLE 30.—AFDC BENEFIT FORMULAS FOR EACH STATE, FOR A MOTHER WITH TWO CHILDREN AND MONTHLY EARNINGS OF $377 IN 1987—Continued

[1987 dollars]

State	Needs standard	Payment standard	Maximum payment	Rateable reduction	Energy disregard	Monthly AFDC benefit
Ohio	674	309	309	1.0	14	37
Oklahoma	471	310	310	1.0	...	38
Oregon	412	412	412	1.0	118	140
Pennsylvania	614	382	382	1.0	...	110
Rhode Island	479	479	479	1.0	128	207
South Carolina	388	388	200	.525	...	61
South Dakota	366	366	366	1.0	...	94
Tennessee	353	353	159	1.0	...	81
Texas	574	184	184	1.0	...	0
Utah	693	693	376	.5430	...	229
Vermont	889	603	603	1.0	...	331
Virginia	393	354	354	1.0	...	82
Washington	835	492	492	1.0	46	220
West Virginia	497	249	249	1.0	...	0
Wisconsin	647	549	549	1.0	...	277
Wyoming	360	360	360	1.0	...	88

Food stamps

Given a wage and AFDC benefit level, the food stamp benefit is calculated using the July 1972, 1976, 1980, 1984, 1985, 1986, and 1987 food stamp parameters, which vary by family size (see table 31).

Earned income tax credit

The EITC in 1987 changed significantly due to the Tax Reform Act of 1986. In 1987, the credit equals 14 percent of the first $6,080 in wages and is phased out at a 10 percent rate for income greater than $6,920. The maximum credit is $851.

The EITC in 1985 and 1986 applies to AFDC families with adjusted gross income (AGI) and earned income below $11,000 annually. The credit equals 11 percent of the first $5,000 in earnings, for a maximum credit of $550 per family. The maximum allowable credit is phased down at 12.22 percent if the individual's AGI (or, if greater, earned income) exceeds $6,500.

For 1980 and 1984, the credit equals 10 percent of the first $5,000 in earnings; it may not exceed $500 per family. In addition, EITC is phased out at a 12.5 percent rate for earnings above $6,000, and only applies to families with AGI and earned income below $10,000 annually. The EITC is counted as earnings for AFDC purposes only in 1984. For 1972, the credit is not applicable, and for 1976 the credit equals 10 percent of the first $4,000 of wages and is phased out at a 10 percent rate between earnings of $4,000 and $8,000.

The size of the credit is not affected by family size.

Federal income taxes

Federal income taxes are calculated using the head of household tax rates, with a standard deduction and exemptions equal to the number of family members.

Federal payroll taxes

Only FICA payroll taxes are included. The tax rate percentage is 5.20, 5.85, 6.13, 6.70, 7.05, 7.15, and 7.15 of wages in 1972, 1976, 1980, 1984, 1985, 1986, and 1987 respectively.

Day care expenses

These are assumed to be 20 percent of wages up to a maximum of $100 per month (1979 dollars). This was the average deduction in AFDC for those families with child care expenses. This maximum was then inflated or deflated to the appropriate year using the Consumer Price Index.

Additional comments

This methodology did not incorporate any other sources of income or expenses although it is possible that these families could have other income sources. The value of health care benefits—in the form of Medicaid or private health insurance—has not been included. A low-income energy assistance grant also was not assumed. However, several States beginning in 1984 (Maryland, New York, Oregon, Rhode Island, and Washington) have designated a portion of their AFDC grant as energy assistance and this is disregarded in calculating the food stamp benefit. The size of the benefit does not affect the family's eligibility for more energy assistance and the primary effect is to increase food stamp benefits. This energy disregard was modeled when food stamp benefits were calculated.

This section examines income in the one month of July which is the month in which AFDC benefits are usually increased. These amounts are then annualized to examine Federal tax policy. To some extent, this is a simplification of the real world. In some States, AFDC benefits vary by season. Food stamp benefit calculations are different at different times of the year. However, there is no reason to believe that annualizing July data presents a misleading picture of Federal and State policy changes between 1972 and 1987.

1988 projection methodology

AFDC benefits levels for 1988 were projected by calculating the nominal AFDC increase in each State from 1984 to 1987 and assuming this same percentage increase would apply between 1987 and 1988. In the model, work expenses remain at the 1987 amount of $105 per month. Food stamp benefits are estimated by using the same methodology as in previous years. Food stamp parameters for 1988 can be found in table 31.

The EITC in 1988 changed significantly due to the Tax Reform Act of 1986. In 1988, the credit will equal 14 percent of the first $6,240 in wages and is phased out at a 10 percent rate for income greater than $9,840. The maximum credit is $874. Provisions in the Tax Reform Act of 1986 changed the standard deduction, the personal exemption amount, and the individual rates. In 1988, the standard deduction for a head of household is assumed to be $4,400. The personal exemption in 1988 is assumed to be $1,950 per person. Thus, the Federal income tax threshold, not taking into account the earned income tax credit, will be $10,250 and $12,200 for a family of three and four, respectively. The FICA rate for 1988 is 7.51 percent.

TABLE 31.—SUMMARY OF KEY MONTHLY FOOD STAMP PARAMETERS FOR JULY OF EACH MODEL YEAR

	1972	1976	1980	1984	1985	1986	1987	1988
Maximum allotment:								
Family of 3	92	130	165	199	208	211	214	228
Family of 4	112	166	209	253	264	268	272	290
Standard deduction	40 [1]	55 [1]	75	89	95	98	99	102
Work expenses	([2])	([2])	20% of wages.	18% of wages.	18% of wages.	20% of wages.	20% of wages.	20% of wages.
Monthly shelter deduction	None	None	45	62.5	67	73.5	74.5	82
Countable income limit:								
Family of 3	NA	$433	$520	$705	$738	$760	$775	$775
Family of 4	$390	$570	$621	$825	$888	$917	$934	$934
Gross income limit:								
Family of 3	None	None	None	$917	$959	$988	$1,008	$1,008
Family of 4	None	None	None	$1,073	$1,154	$1,192	$1,214	$1,214

[1] In addition, the monthly purchase requirement table had a $30 deduction amount built into the table. These amounts include the shelter deduction.

[2] Work expense deduction in 1972 and 1976 equals actual taxes plus 10 percent of wages, up to $275 annually in 1972 and $375 annually in 1976.

NA=Not applicable.

APPENDIX H. DEMOGRAPHIC AND ECONOMIC CHARACTERISTICS OF THE ELDERLY

This appendix presents selected historical and current data on the demographic and economic characteristics of the elderly. Tables 1 through 20 present characteristics of the overall elderly population, including: population and life expectancy trends; marital status and living arrangements; labor force participation; poverty statistics; income sources; and Federal spending and tax policy. Tables 21 through 26 present characteristics of new retirees and newly disabled beneficiaries. Date sources are noted at the bottom of each table.

The following definitions may be useful for reading the tables:

(1) "Aged" and "elderly" each refer to any person 65 years old or older.

(2) "OASDI" and "Social Security" are used interchangeably.

(3) "Supplemental security income" is, at times, abbreviated "SSI."

(4) The concepts "unrelated individual" and "unit" are used many times throughout this appendix. "Unrelated individual" refers to any individual living alone. "Unit" refers to an individual living alone, a couple living alone or a family.

POPULATION

The U.S. population is aging. As table 1 illustrates, there has been and will continue to be a dramatic increase in the proportion of the population which is elderly. The elderly represented 6.7 percent of the population in 1940, 11.1 percent in 1980, and are projected to represent 12.9 percent of the population by the year 2000. The actual number of elderly individuals is expected to quadruple between 1940 and 2000, and increase by roughly 40 percent between 1980 and 2000.

The percentages of the population that are 75 and over and 85 and over will grow at a faster rate than the overall elderly population. Between 1980 and 2000, the percentage of the population that is over age 75 is projected to increase from 4.4 to 6.2 percent. The percentage of the population that is age 85 and over is projected to increase from 1 to 1.7 percent.

TABLE 1.—ELDERLY POPULATION AS PERCENT OF TOTAL POPULATION AND DISTRIBUTION OF ELDERLY BY AGE AND SEX, SELECTED YEARS 1940 TO 2025, AS OF JULY 1

	1940	1950	1960	1970	1980	1990[1]	2000[1]	2025[1]
Population 65 years and older (in thousands)	9,194	12,706	17,094	20,741	26,102	31,911	35,626	60,868
Population age 65 and older as a percent of total population	6.7	8.0	9.0	9.6	11.1	12.4	12.9	19.7
Population age 75 and older as a percent of total population	2.1	2.7	3.1	3.8	4.4	5.3	6.2	8.4
Population age 85 and older as a percent of total population	.3	.4	.5	.7	1.0	1.3	1.7	2.3
Certain age and sex groupings as a percent of the population 65 years and older:								
Total 65 years and older	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Men 65 and older	48.5	46.8	44.6	41.5	40.3	40.6	40.8	43.4
Men 65 to 74	34.2	32.1	30.4	26.5	26.3	25.7	23.6	27.2
Men 75 to 84	12.5	12.7	12.0	12.5	11.3	12.0	13.5	12.7
Men 85 and older	1.8	2.0	2.2	2.5	2.7	2.9	3.7	3.5
Women 65 and older	51.5	53.2	55.4	58.5	59.7	59.4	59.2	56.6
Women 65 to 74	34.3	34.4	35.6	34.0	33.9	31.8	28.2	30.1
Women 75 to 84	14.5	15.7	16.3	19.6	19.3	20.1	21.4	18.3
Women 85 and older	2.5	3.1	3.5	4.9	6.5	7.5	9.6	8.2

[1] Projection.

Note: Population data for 1940 and 1950 include coterminous U.S. only; 1960 and 1970 refer to total U.S. population; 1980 to 2025 refer to total U.S. plus the outlying areas and include an adjustment for the population under count.

Source: 1940 to 1970, U.S. Bureau of the Census, U.S. Census of Population, 1940, 1960, and 1970; 1980 to 2025, 1987 Annual Reports of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, and unpublished estimates from the Office of the Actuary, Social Security Administration.

Trends in Life Expectancy

Table 2 presents data on life expectancies both at birth and at age 65 for men and women. These data cover the historical period 1900 through 1980, and the projected period 1990 through 2060. On average, a female born in 1900 could expect to live 48 years; a female born in 1980 could expect to live more than 77 years. Life expectancies at birth have increased so dramatically primarily because infant and child mortality rates have decreased, but also because individuals who live to adulthood are living longer. A male reaching age 65 in 1900 could expect to live another 11 years on average; a male reaching age 65 in 1980 could expect to live another 14 years. Life expectancies at birth and at age 65 are expected to continue to increase.

TABLE 2.—ACTUAL AND PROJECTED LIFE EXPECTANCIES AT BIRTH AND AT AGE 65 FOR MEN AND WOMEN: 1900–2060

Year	Life expectancy at birth		Life expectancy at age 65	
	Male	Female	Male	Female
Actual:				
1900	46.3	48.3	11.3	12.0
1910	48.4	51.8	11.4	12.1
1920	53.6	54.6	11.8	12.3
1930	58.1	61.6	11.8	12.9
1940	60.8	65.2	11.9	13.4
1950	65.6	71.1	12.8	15.1
1960	66.6	73.1	12.9	15.9
1970	67.1	74.7	13.1	17.1
1980	70.0	77.5	14.1	18.3
Projected:				
1990	71.6	79.2	15.0	19.5
2000	72.9	80.5	15.7	20.5
2010	73.8	81.5	16.1	21.2
2020	74.2	82.0	16.5	21.7
2030	74.6	82.5	16.8	22.1
2040	75.0	83.1	17.1	22.6
2050	75.5	83.6	17.4	23.1
2060	75.9	84.1	17.8	23.6

Source: 1900 to 1980: At Birth: National Center for Health Statistics. Vital Statistics of the United States, 1980. Vol II—Mortality. Hyattsville, MD. 1985. At Age 65: Social Security Administration. Social Security Area Population Projections. 1985. Actuarial Study No. 95. SSA Pub. No. 11-11542. October 1985. 1990 to 2060: U.S. Bureau of the Census. Projections of the Population of the United States, by Age, Sex, and Race: 1983 to 2080. Current Population Reports. Series P-25. No. 952. Washington, DC. May 1984. Table B-5.

Marital Status and Living Arrangements

Tables 3 and 4 present information on the marital status and living arrangements of noninstitutionalized aged individuals for 1970, 1980 and 1986.

Perhaps the most striking statistics are those which apply to elderly women. In each of the 3 years, roughly 40 percent of elderly women ages 65 to 74, and roughly 70 percent of elderly women ages 75 and over, were widows. Because the size of the elderly population grew between 1970 and 1986, this implies increasing numbers of widowed elderly women in the United States. There were 5.9 million widowed women over age 65 in 1970 and 8.1 million by 1986, representing a 36 percent increase.

A large and increasing fraction of all noninstitutionalized widowed women live alone. Over 68 percent of widowed women lived alone in 1986, compared with 56 percent in 1970. As a result of this increase, the number of widowed women living alone has grown even faster than the overall number of widowed women. Between 1970 and 1986, the number of widowed women living alone increased 68 percent, from 3.3 to 5.6 million.

TABLE 3.—MARITAL STATUS OF AGED INDIVIDUALS,[1] BY SEX AND AGE, 1970, 1980, AND 1986

	1970		1980		1986	
	65 to 74	75 and over	65 to 74	75 and over	65 to 74	75 and over
Men:						
Number (in thousands)	5,333	3,031	6,459	3,234	7,440	3,832
Percent	100.0	100.0	100.0	100.0	100.0	100.0
Married, wife present	74.6	57.5	79.4	67.7	79.2	67.9
Married, wife absent	3.0	4.0	2.2	1.7	1.9	1.9
Widowed	11.0	30.4	8.5	24.0	9.1	22.5
Divorced	2.9	1.5	4.4	2.2	4.6	2.7
Never married	8.5	6.6	5.4	4.4	5.2	5.0
Women:						
Number (in thousands)	6,741	4,608	8,549	5,411	9,439	6,610
Percent	100.0	100.0	100.0	100.0	100.0	100.0
Married, husband present	43.8	18.9	48.1	22.1	49.2	22.8
Married, husband absent	1.6	1.9	2.0	1.2	2.1	1.1
Widowed	43.7	70.5	40.3	68.0	38.8	67.1
Divorced	3.0	1.3	4.0	2.3	5.5	2.7
Never married	7.9	7.4	5.6	6.4	4.4	6.3

[1] Civilian noninstitutional population only.

Note: Details may not add to totals due to rounding.

Source: U.S. Bureau of the Census, Current Population Reports, series P-20, Nos. 212, 365, and unpublished data.

TABLE 4.—LIVING ARRANGEMENTS OF PERSONS AGED 65 AND OVER,[1] 1970, 1980, AND 1986

[Civilian noninstitutionalized population, number in thousands]

Living arrangement	Total 65 and over	Percent	Widowed men	Percent	Widowed women	Percent
Total:						
1970	19,061	100.0	1,333	100.0	5,946	100.0
1980	24,194	100.0	1,342	100.0	7,295	100.0
1986	27,321	100.0	1,541	100.0	8,099	100.0
In families:						
1970	13,347	70.0	499	37.4	2,386	40.1
1980	16,355	67.6	385	28.7	2,194	30.1
1986	18,389	67.3	468	30.4	2,318	28.6
Living alone:						
1970	5,071	26.6	708	53.1	3,309	55.7
1980	7,328	30.3	893	66.5	4,916	67.4
1986	8,318	30.4	978	63.5	5,566	68.7
Other:						
1970	645	3.4	124	9.3	251	4.2
1980	511	2.1	65	4.8	186	2.5
1986	614	2.3	95	6.1	215	2.7

[1] Excludes persons in institutions (nursing homes, etc.). The number of such persons age 65 years and over was estimated to be 0.8 million in 1970, and 1.3 million in 1980, and in 1986.

Source: Bureau of the Census, Current Population Reports, P-20, No. 376 and unpublished data.

LABOR FORCE PARTICIPATION

Table 5 presents information on the labor force participation rates of men and women ages 55 and over for selected years between 1950 and 1987. Since 1950, the labor force participation rate for men in this age group has steadily declined. For men ages 55 to 64, the rate has declined from 87 to 68 percent. For men ages 65 and over, the rate has declined from 46 to 16 percent. The trend looks different for women. The participation rate for women ages 55 to 64 has increased from 27 percent in 1950 to 43 percent in 1987. The rate for women ages 65 and over has decreased from 10 percent in 1950 to 7 percent in 1987.

TABLE 5.—CIVILIAN LABOR FORCE PARTICIPATION RATES [1] OF PERSONS 55 YEARS AND OVER, BY AGE AND SEX, SELECTED YEARS, 1950–87

Age	1950	1955	1960	1965	1970	1975	1980	1985	1986	1987
Men:										
55 to 64	86.9	87.9	86.8	84.6	83.0	75.8	72.3	67.9	67.3	67.6
55 to 59	(2)	92.5	91.6	90.2	89.5	84.4	81.9	79.6	79.0	79.7
60 to 64	(2)	82.5	81.1	78.0	75.0	65.7	61.0	55.6	54.9	54.9
60 to 61	(2)	(2)	(2)	84.8	82.6	75.2	71.8	68.9	67.7	67.6
62 to 64	(2)	(2)	(2)	73.2	69.4	58.8	52.8	46.1	45.8	46.0
65 and over	45.8	39.6	33.1	27.9	26.8	21.7	19.1	15.8	16.0	16.3
Women:										
55 to 64	27.0	32.5	37.2	41.4	43.0	41.0	41.5	42.0	42.3	42.7
55 to 59	(2)	35.6	42.2	47.1	50.4	47.9	48.6	50.3	51.3	52.2
60 to 64	(2)	29.0	31.4	34.0	36.1	33.3	33.3	33.4	33.2	33.2
60 to 61	(2)	(2)	(2)	40.4	41.4	39.5	39.8	40.3	40.0	41.0
62 to 64	(2)	(2)	(2)	29.5	32.3	29.0	28.6	28.7	28.5	27.8
65 and over	9.7	10.6	10.8	10.0	9.7	8.3	8.1	7.3	7.4	7.4

[1] Civilian labor force as percent of civilian population.

[2] Data not available.

Source: Monthly Labor Review, November 1979, 1981 Employment and Training Report of the President; January issue of Employment and Earnings; and unpublished data from the Bureau of Labor Statistics.

POVERTY STATUS OF THE ELDERLY [1]

Table 2 in Appendix I shows that the elderly have a lower incidence of poverty than does the population as a whole. In 1987, 12.4 percent of the noninstitutionalized aged were poor, or 3.5 million individuals. This compares to the overall poverty rate of 13.6 percent. In spite of the slightly lower incidence of poverty, poverty rates among the aged vary considerably.

Table 6 presents information on the poverty status of elderly individuals by sex, race and family status. The poverty rate for aged women was almost twice the poverty rate for aged men in 1986. The poverty rate among the black aged was higher in 1986 than that of the white aged—24.2 percent of black aged men and 35.5 percent of black aged women were poor, compared with 6.9 percent of white men and 13.3 percent of white women.

Unrelated aged individuals had much higher poverty rates than aged persons living in families. White unrelated individuals had lower poverty rates than black unrelated individuals.

Table 7 presents additional information on the poverty status of the elderly, this time broken down by sex and marital status. This table shows that some of the difference in the incidence of poverty between aged men and aged women appears to be due to differences in marital status. Comparing married men and women, the incidence of poverty is essentially the same at each age. Among aged men, poverty rates are highest among those who are never married and among widowed men ages 85 and over. Among aged women, poverty rates are highest among those who are divorced or separated, followed by women who are widowed and those who are never married.

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[1] Please see Appendix I for additional poverty data related to the elderly. Appendix I provides details on how poverty is measured, statistics on trends in the overall poverty rate, and comparisons of the poverty rate among selected demographic groups, including the elderly.

TABLE 6.—CHANGES IN POVERTY STATUS OF ALL PERSONS, AND THE ELDERLY BY SEX, RACE, AND FAMILY STATUS, SELECTED YEARS: 1959 TO 1986

[Percent below the poverty level]

	1959	1966	1970	1975	1980	1983 [1]	1984 [1]	1985 [1]	1986 [2]
All persons	22.4	14.7	12.6	12.3	13.0	15.2	14.4	14.0	13.6
Persons 65 years old and over									
Both sexes	35.2	28.5	24.5	15.3	15.7	14.1	12.4	12.6	12.4
Men	NA	23.7	19.0	11.4	10.9	10.0	8.7	8.5	8.5
Black men [3]	NA	52.2	41.3	31.0	31.5	28.3	25.9	26.5	24.2
Heads of households	60.4	50.0	39.2	26.0	25.0	21.3	19.6	21.0	19.4
Unrelated individuals	77.5	72.7	59.7	51.8	45.4	45.9	43.4	40.6	39.8
White men [3]	NA	21.3	17.0	9.5	9.0	8.2	7.2	6.9	6.9
Heads of households	26.8	18.7	13.8	7.1	6.9	6.1	5.2	4.9	4.9
Unrelated individuals	56.8	41.3	36.0	23.8	21.1	18.5	17.3	17.6	16.7
Women	NA	32.1	28.4	18.1	19.0	17.0	15.0	15.6	15.2
Black women [3]	NA	57.3	53.2	40.2	42.6	41.7	35.6	34.8	35.5
Wives	57.7	51.9	41.8	23.8	23.5	17.6	17.6	17.5	14.4
Unrelated individuals	84.6	83.9	79.2	65.8	66.6	63.6	56.6	55.4	59.7
White women [3]	NA	30.3	26.5	16.1	16.8	14.7	13.1	13.8	13.3
Wives	28.9	20.2	14.0	7.2	7.0	6.3	5.3	4.7	4.8
Unrelated individuals	61.8	55.2	47.5	29.1	29.3	24.5	22.5	24.3	23.7

[1] The poverty definition used to produce the estimates for 1981 and years after changed slightly from previous years. If the new method were used for 1980, the heading "All persons" would read 13.2 percent below the poverty level, not 13.0 percent. In 1984, a new method of imputing missing values was utilized and new population weights were used. A comparable number for 1983 of the poverty rate for all persons was 15.3 percent.

[2] 1986 figures prepared by the Congressional Research Service, using the March 1987 Current Population Survey computer tapes.

[3] Total includes other types of family members not separately designated.

NA—Not available.

Sources: U.S. Bureau of the Census, Current Population Reports series P–60 referring to the population below the poverty level, various years in series; unpublished data.

TABLE 7.—POVERTY RATES AMONG PERSONS AGE 65 AND OLDER BY AGE, SEX, AND MARITAL STATUS: 1985

	65 and over	65 to 74	75 to 84	85 and over
Male total	8.5	7.5	9.2	16.6
Married	5.9	5.5	6.1	9.7
Widowed	14.7	12.5	13.3	23.6
Divorced/separated	16.4	14.9	18.9	NA
Never married	22.8	19.8	28.0	NA
Female total	15.6	13.0	19.2	19.7
Married	6.1	5.5	7.6	10.7
Widowed	21.3	19.8	23.4	20.3
Divorced/separated	27.9	27.4	31.0	NA
Never married	18.8	16.5	20.1	24.2

Source: March 1986 Current Population Survey (CPS).

NA—Not available due to unreliability of estimate. Percentage base represents fewer than 75,000 persons.

INCOME SOURCES OF THE ELDERLY

As noted in the previous subsection, most elderly individuals had incomes above the poverty threshold in 1986, although a sizeable minority was poor. Tables 8 through 13 provide insight into the sources and distribution of income among the elderly population. The percentage of the aged represented in the various tables is shown below.

CHARACTERISTICS OF AGED UNITS: 1987

Description of unit	Number of units (in thousands)	Number of persons age 65 and older (in thousands)	Percent of elderly
All persons in unit age 65 and over	14,870	20,708	70.6
All persons in unit age 75 and over	5,747	7,081	24.1
At least one person age 65 or older	21,285	27,975	95.3
Family head age 65 or older	19,420	25,939	88.4
Number of aged not represented by the current population survey		1,372	4.7

Note: Units are comprised of families and unrelated individuals.

Source: March 1987 Current Population Survey. Table prepared by CRS.

Table 8 provides information for 1986 on the percentage of non-institutional elderly units (all members ages 65 and over) with income from various sources, broken down by income level. Note that the bottom rows of table 8 present characteristics of persons in elderly units, by income level of the unit. The majority of these units has combined income above the poverty level (83 percent). As one would expect, the fraction of units with income from earnings generally rises as income rises. For example, 4 percent of the units with income less than the poverty threshold had income from earnings, compared with 18 percent of the units with income above the poverty threshold. Although overall 95 percent of the units had income from Social Security, only 57 percent of those with income less than 50 percent of the poverty threshold had income from Social Security. Generally, poor elderly units are less likely than nonpoor elderly units to receive income from pensions and from interest and dividends, and more likely to receive income from AFDC, SSI, general assistance, food stamps, and housing assistance.

Table 9 describes the percent of the total income of elderly units which derives from various sources, broken down by income level. This table shows that 1.3 percent of total family income for poor units is comprised of earnings, compared with 10.7 percent of nonpoor units. Pension income accounts for 2.3 percent of total income received by poor units, while it comprises 16.3 percent for nonpoor units. Social Security and SSI income together represents 90.3 percent of total income for poor units and approximately 40.9 percent for nonpoor units. Interest and dividend income represents 4.1 percent of total income for poor units and 30.4 percent for nonpoor units.

Similar data to those presented in tables 8 and 9 are presented in table 10, which focuses specifically on elderly units with all members ages 75 and over. This table shows that a larger percentage of the units comprised of the very old are poor. However, the pattern of income sources for both the poor and nonpoor units is not substantially different among this older elderly group than it was among the younger elderly group described above. The most significant diffference is that only 5.6 percent of the units ages 75 and over have income from earnings, compared with 15.5 percent of the units ages 65 and over. These older aged individuals are also less likely to receive pension income and are more likely to receive income from means-tested programs.

Table 11 is the same as table 10 except that it focuses on units in which *any* member is age 65 or over. Table 12 provides information on the percentage distribution of selected sources of income between poor and nonpoor units in which at least one member is age 65 or over. These data include families with an aged member and elderly individuals living alone.

TABLE 8.—PERCENT OF UNITS [1] WITH ALL MEMBERS AGE 65 OR OVER WITH INCOME FROM VARIOUS SOURCES, BY THE RATIO OF TOTAL INCOME TO THE POVERTY THRESHOLD,[2] 1986

	Ratio of total income to poverty threshold								Poor	Nonpoor	Total
	Under 0.50	0.50 to 0.74	0.75 to 0.99	1.00 to 1.24	1.25 to 1.49	1.50 to 1.99	2.00 to 2.99	3.00 and over			
Number of units (in thousands)	399	503	1,691	1,662	1,364	2,053	2,871	4,328	2,592	12,278	14,870
Percent of units	2.7	3.4	11.4	11.2	9.2	13.8	19.3	29.1	16.9	82.6	100.0
Earnings	4.0	5.0	3.5	5.3	6.9	11.4	17.5	29.7	3.9	17.9	15.5
OASDI, railroad retirement	57.2	91.3	92.5	97.8	98.1	98.7	97.5	94.9	86.9	96.9	95.1
Pensions	7.6	4.3	5.9	13.6	22.7	38.7	56.8	61.8	5.9	45.9	38.9
Unemployment compensation, workers compensation, veterans payments	2.5	4.4	4.9	7.1	6.1	5.3	5.2	6.0	4.4	5.8	5.6
AFDC, SSI, general assistance	11.3	15.9	31.8	9.1	9.8	2.8	1.2	.3	25.5	3.2	7.1
Child support, alimony	4.6	.9	2.7	2.2	2.3	3.1	1.7	3.0	2.7	2.5	2.5
Interest, dividends	34.0	30.8	29.7	49.2	56.4	73.0	86.4	95.3	30.6	78.9	70.5
Food stamps	11.1	16.9	26.4	7.3	2.3	.9	.1	.0	22.2	1.4	5.0
Housing assistance	13.4	16.5	19.8	17.7	10.8	7.4	3.0	.8	18.2	5.8	8.0
CHARACTERISTICS OF PERSONS											
Number of people (thousands)	466	557	1,852	1,916	1,743	2,861	4,367	6,946	2,875	17,833	20,708
Percent white non-Hispanic [3]	79.1	72.9	78.5	84.5	87.2	92.0	93.6	96.9	77.5	93.0	90.9
Percent black non-Hispanic	16.2	23.0	16.7	12.1	10.9	5.7	4.9	2.0	17.9	5.3	7.0
Percent Hispanic	4.7	4.1	4.8	3.4	1.9	2.3	1.5	1.1	4.7	1.7	2.1
Percent unrelated individuals	71.2	80.4	82.7	73.7	56.9	44.0	32.6	25.7	80.4	38.5	44.4
Percent female	75.9	77.5	76.2	72.7	67.6	63.7	58.8	56.6	76.4	61.1	63.2
Percent age 75 and over	55.2	48.8	53.8	55.8	50.3	47.9	38.4	32.2	53.0	40.5	42.3
Percent female and age 75 and over	41.1	37.1	40.3	42.0	33.4	29.2	21.9	16.9	39.8	24.4	26.5

[1] Includes unrelated individuals (elderly living alone). [2] Based on census ("Orshansky") poverty levels. [3] Includes "other" races.

Source: March 1987 Current Population Survey (CPS). Table prepared by CRS.

TABLE 9.—PERCENT OF TOTAL UNIT INCOME [1] FROM VARIOUS SOURCES, BY THE RATIO OF TOTAL INCOME TO THE POVERTY THRESHOLD,[2] FOR UNITS WITH ALL MEMBERS AGE 65 OR OVER, 1986

	Ratio of total income to poverty threshold—poverty ratio								Poor	Nonpoor	Total
	Under 0.50	0.50 to 0.74	0.75 to 0.99	1.00 to 1.24	1.25 to 1.49	1.50 to 1.99	2.00 to 2.99	3.00 and over			
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Earnings	2.4	1.7	1.1	1.4	1.8	2.8	6.0	14.5	1.3	10.7	10.3
OASDI, railroad retirement	70.2	81.4	78.5	84.5	79.3	72.4	54.7	26.1	78.5	40.5	42.1
Pensions	6.1	2.2	2.1	3.6	5.2	8.9	17.3	18.7	2.3	16.3	15.7
Unemployment compensation, workers compensation, veterans payments	1.2	1.3	1.4	1.7	1.6	1.5	1.4	.8	1.4	1.0	1.1
AFDC, SSI, general assistance	6.3	8.3	12.9	3.3	3.3	1.0	.2	.0	11.8	.4	.9
Child support, alimony	1.6	.3	.6	.4	.4	.5	.3	.7	.6	.6	.6
Interest, dividends	12.2	4.8	3.4	5.2	8.3	13.0	20.1	39.2	4.1	30.4	29.3
Food stamps [3]	(4.7)	(2.2)	(2.0)	(.4)	(.1)	(.0)	(.0)	(.0)	(2.1)	(.0)	(.1)
Housing assistance [3]	(10.2)	(7.8)	(8.3)	(4.8)	(2.5)	(1.0)	(.2)	(.0)	(8.3)	(.5)	(.8)
Mean cash income per family member	$1,033	$3,137	$4,274	$5,308	$6,065	$7,245	$9,725	$21,365	$3,528	$13,028	$11,709
Mean family size	1.2	1.1	1.1	1.2	1.3	1.4	1.5	1.6	1.1	1.5	1.4

[1] Only for units with non-negative income.

[2] Based on census ("Orshansky") poverty levels.

[3] The cash value of food stamps and housing assistance were estimated using their market values. Their cash values are excluded from total income for purposes of determining poverty status as well as for calculating the percentage share of total income. The numbers in this row for food stamps and housing assistance represent the added percentage contribution to total cash income.

Source: March 1987 Current Population Survey (CPS). Table prepared by CRS.

TABLE 10.—PERCENT OF UNITS [1] WITH ALL MEMBERS AGE 75 OR OVER WITH INCOME FROM VARIOUS SOURCES, AND PERCENT OF TOTAL UNITS INCOME FROM EACH SOURCE, BY POVERTY [2] STATUS: 1986

	Percent of units with income from each source			Percent of units income from each source		
	Total	Poor	Nonpoor	Total	Poor	Nonpoor
Number of units (in thousands)	5,747	1,270	4,477	NA	NA	NA
Number of individuals	7,081	1,385	5,696	NA	NA	NA
Percent of units	100.0	22.1	77.9	NA	NA	NA
Earnings	5.6	1.6	6.8	2.6	0.5	2.7
OASDI, railroad retirement	95.6	87.2	98.0	48.0	79.5	45.7
Pensions	31.9	5.8	39.3	13.7	2.2	14.6
Unemployment compensation, workers compensation, veterans payments	4.1	4.0	4.1	0.9	1.4	0.9
AFDC, SSI, general assistance	8.1	24.0	3.6	1.3	11.0	0.6
Child support, alimony	2.5	2.7	2.5	0.6	0.5	0.6
Interest, dividends	68.8	33.4	78.8	32.9	4.9	35.0
Food stamps [3]	5.8	21.1	1.5	(0.2)	(1.8)	(0)
Housing assistance [3]	10.4	18.1	8.2	(1.3)	(8.3)	(0.9)

[1] Includes both families and unrelated individuals.

[2] Based on census ("Orshansky") poverty levels.

[3] The cash values of food stamps and housing assistance were estimated using their market values. Their cash values are excluded from total income for purposes of determining poverty status as well as for calculating the percentage share of total income. The numbers in parentheses for food stamps and housing assistance represent the added percentage contribution to total cash income.

NA—Not applicable.

Source: March 1987 Current Population Survey (CPS). Table prepared by CRS.

TABLE 11.—PERCENT OF UNITS [1] WITH ANY MEMBER AGE 65 OR OVER WITH INCOME FROM VARIOUS SOURCES, AND PERCENT OF TOTAL UNIT INCOME FROM EACH SOURCE, BY POVERTY [2] STATUS: 1986

	Percent of units with income from each source			Percent of unit income from each source		
	Total	Poor	Nonpoor	Total	Poor	Nonpoor
Number of units (in thousands)	21,285	3,136	18,149	NA	NA	NA
Number of aged individuals	27,975	3,477	24,499	NA	NA	NA
Percent of units	100.0	14.7	85.3	NA	NA	NA
Earnings	32.5	9.1	36.6	30.4	5.4	31.2
OASDI, railroad retirement	92.6	86.5	93.7	31.8	73.8	30.4
Pensions	39.7	7.1	45.3	13.1	2.5	13.5
Unemployment compensation, workers compensation, veterans payments	8.4	5.0	8.9	1.2	1.6	1.2
AFDC, SSI, general assistance	8.5	27.4	5.3	1.0	12.4	0.6
Child support, alimony	3.9	3.2	4.1	0.6	0.7	0.6
Interest, dividends	70.1	29.5	77.1	21.9	3.6	22.5
Food stamps [3]	5.2	23.5	2.0	(0.1)	(2.8)	(0.0)
Housing assistance [3]	6.0	16.4	4.3	(0.5)	(6.7)	(0.3)

[1] Includes both families and unrelated individuals

[2] Based on census ("Orshansky") poverty levels.

[3] The cash values of food stamps and housing assistance were estimated using their market values. Their cash values are excluded from total income for purposes of determining poverty status as well as for calculating the percentage share of total income. The numbers in parentheses for food stamps and housing assistance represent the added percentage contribution to total cash income.

NA—Not applicable.

Source: March 1987 Current Population Survey (CPS). Table prepared by CRS.

TABLE 12.—PERCENTAGE DISTRIBUTION OF SELECTED SOURCES OF INCOME RECEIVED BY UNITS WITH AN AGED MEMBER,[1] BY FAMILY MONEY INCOME AS A RATIO OF THE POVERTY LEVEL, 1986

[In percent]

Type of income	Percent received by units with aged individuals	Ratio of total income to poverty threshold									Poor	Non-poor
		Total	Under 0.50	0.50 to 0.74	0.75 to 0.99	1.00 to 1.24	1.25 to 1.49	1.50 to 1.99	2.00 to 2.99	3.00 and over		
Total income	16.6	100.0	0.2	0.6	2.3	3.0	3.2	6.8	16.1	67.8	3.1	96.9
Social security and railroad retirement	83.9	100.0	.4	1.4	5.4	7.3	7.2	13.6	23.0	41.6	7.3	92.8
SSI	42.5	100.0	1.5	6.4	30.8	14.2	14.1	11.9	9.9	11.1	38.8	61.2
AFDC and general assistance	5.5	100.0	2.3	8.3	20.0	17.4	16.3	13.7	14.0	8.0	30.7	69.3
Food stamps	7.7	100.0	9.5	20.2	38.6	13.7	5.3	6.2	3.9	2.4	68.4	31.6
Unemployment compensation, workers compensation, and veterans payments	19.2	100.0	.3	1.0	2.7	5.7	4.8	11.7	21.8	52.0	4.0	96.0
Wages, salaries, farm and self-employment	6.4	100.0	.0	.1	.4	.7	1.0	2.6	11.6	83.5	.5	99.5
Pensions	57.9	100.0	.1	.1	.4	.8	1.3	4.9	18.2	74.1	.6	99.4
Child support, alimony	8.7	100.0	.4	.5	2.8	3.1	3.8	8.3	14.3	66.8	3.7	96.3
Property income	48.6	100.0	.1	.1	.3	.7	1.0	3.3	11.0	83.5	.5	99.5

[1] Includes families with an aged member and aged unrelated individuals living alone.

Note: This table shows for families with at least one aged member the percentage of selected sources of income received by families classified by poverty level. The first number in the first column, 16.6 percent, means that 16.6 percent of all income accrues to families that include an aged member. The next number in the first row means 0.2 percent of all income received by these families accrues to those families that have an income of less than 50 percent of the poverty level.

Source: March 1987 Current Population Survey (CPS). Table prepared by CRS.

Tables 13 through 15 provide data from the Current Population Survey for 1986.[2] Table 13 shows the distribution of the share of total family income which is comprised of Social Security income. The tables include all units where the head is age 65 and over, including families and unrelated individuals as well. For example, for elderly units in poverty, Social Security represents over 90 percent of their income in 50.5 percent of such families. In less than 1 percent of elderly families with income three times the poverty level does Social Security income constitute more than 90 percent of total family income.

Table 14 presents similar information except that it shows the percent of family income derived from supplemental security income (SSI) and Social Security benefits combined.

Table 15 presents the number of families with an aged head with different combinations of SSI, Social Security or railroad retirement, and food stamp income. For families in poverty, 86.9 percent receive Social Security or railroad retirement, 25 percent receive SSI, and 23.5 percent receive food stamp benefits. Only 11.4 percent of elderly families under poverty receive all three types of income.

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[2] Withdrawals from savings are not included as income on the CPS. For the aged in particular, dissaving may provide an important means of maintaining a desired level of consumption.

TABLE 13.—SOCIAL SECURITY INCOME AS A PERCENT OF TOTAL UNIT INCOME,[1] BY RATIO OF TOTAL INCOME TO THE POVERTY THRESHOLD, FOR UNITS WITH A HEAD AGE 65 OR OVER, 1986

[In percent]

	Ratio of total income to poverty threshold										
	Total	Under 0.50	0.50 to 0.74	0.75 to 0.99	1.00 to 1.24	1.25 to 1.49	1.50 to 1.99	2.00 to 2.99	3.00 and over	Poor	Nonpoor
Number of units (thousands)	19,101	451	629	1,893	1,868	1,556	2,501	3,802	6,401	2,973	16,128
Number of individuals aged 65 and over (thousands)	25,512	522	699	2,078	2,157	1,960	3,362	5,425	9,309	3,299	22,213
Total (percent of units)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Social Security as a percent of total income:											
0.1 to 24.9	16.4	.9	2.4	1.8	1.8	2.3	2.9	9.6	40.1	1.8	19.1
25 to 49.9	24.8	4.6	3.7	6.3	6.8	10.5	15.8	33.7	40.7	5.5	28.3
50 to 79.9	25.7	8.6	18.2	24.9	19.9	29.1	45.0	44.7	9.9	21.0	26.6
80 to 89.9	6.7	4.1	7.4	9.3	14.0	16.0	13.5	4.4	.4	8.1	6.5
90 or more	20.0	[2]38.7	59.0	50.5	54.6	39.4	20.5	4.3	.3	50.5	14.4
Percent of units with Social Security income	93.6	56.9	90.8	92.8	97.1	97.3	97.7	96.7	91.4	86.9	94.9
Percent of units without Social Security income	6.4	43.1	9.2	7.2	2.9	2.7	2.3	3.3	8.6	13.1	5.1

[1] For units with non-negative income only.

[2] The number 38.7 in the second column means that 38.7 percent of units with a head over age 65 with total incomes less than 50 percent of poverty depend upon social security benefits for 90 percent or more of their income.

Source: March 1987 Current Population Survey (CPS). Table prepared by CRS.

TABLE 14.—SOCIAL SECURITY AND SUPPLEMENTAL SECURITY INCOME AS A PERCENT OF TOTAL UNIT INCOME,[1] BY RATIO OF TOTAL INCOME TO THE POVERTY THRESHOLD, FOR UNITS WITH A HEAD AGE 65 OR OVER, 1986

	Ratio of total income to poverty threshold										
	Total	Under 0.50	0.50 to 0.74	0.75 to 0.99	1.00 to 1.24	1.25 to 1.49	1.50 to 1.99	2.00 to 2.99	3.00 and over	Poor	Nonpoor
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Social Security and SSI as a percent of total income:											
0.1 to 24.9	16.3	1.8	2.3	1.7	1.7	2.0	2.8	9.5	40.1	1.8	19.0
25 to 49.9	24.2	4.2	2.2	3.2	5.2	8.6	15.9	33.7	40.8	3.1	28.0
50 to 79.9	23.2	7.5	11.5	12.1	16.1	24.8	42.9	44.8	10.0	11.3	25.4
80 to 89.9	6.4	2.5	5.7	7.0	13.7	16.2	13.5	4.4	.4	6.0	6.5
90 or more	24.7	[2]47.5	74.0	74.1	61.4	46.4	22.8	4.6	.3	70.0	16.3
Percent of families with Social Security and/or SSI income	94.8	63.5	95.8	98.1	98.2	98.1	98.0	96.9	91.6	92.3	95.2
Percent of families without Social Security or SSI income	5.2	36.5	4.2	1.9	1.8	1.9	2.0	3.1	8.4	7.7	4.8

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[1] For units with non-negative income only.

[2] The number 47.5 in the second column means that 47.5 percent of families with a head over age 65 with total incomes less than 50 percent of poverty depend upon social security and/or SSI benefits for 90 percent or more of their income.

Source: March 1987 Current Population Survey (CPS). Table prepared by CRS.

TABLE 15.—RECEIPT OF SOCIAL SECURITY, SUPPLEMENTAL SECURITY INCOME, FOOD STAMPS, AND COMBINATIONS THEREOF, AMONG FAMILIES[1] WITH AN AGED HEAD CLASSIFIED BY FAMILY MONEY INCOME AS A PERCENT OF THE POVERTY THRESHOLD: 1986

Type of benefit	Less than 100 percent of poverty threshold		100 to 149.9 percent of poverty threshold	
	Number (in thousands)	Percent	Number (in thousands)	Percent
Social Security[2]	2,632	86.9	3,374	97.2
SSI	758	25.0	373	10.7
Food stamps	711	23.5	232	6.7
Social Security only[3]	1,784	58.9	2,919	84.1
SSI only[3]	57	1.9	22	0.6
Food stamps only[3]	11	0.4	7	0.2
Social Security and food stamps[4]	252	8.3	114	3.3
Social Security and SSI[4]	253	8.3	240	6.9
SSI and food stamps[4]	104	3.4	10	0.3
All three income sources	344	11.4	100	2.9
No Social Security, SSI, or food stamps	222	7.3	56	1.6
Total	3,027		3,471	

[1] Includes unrelated individuals and elderly individuals living alone.

[2] Includes railroad retirement.

[3] Row 4 which is labeled "social security only" means the family only receives social security and does not receive SSI or food stamps. The family could be receiving other types of income. The same is true of rows 5 and 6.

[4] Family receives only the two types of income specified but not the third. The family could be receiving other sources of income than the three mentioned.

Source: March 1987 Current Population Survey (CPS). Table prepared by CRS.

PER CAPITA INCOME BY AGE OF HEAD

Table 16 shows the average income per household member before and after taxes for calendar years 1980 and 1985. Taxes simulated in the study included Federal income taxes, State individual income taxes, property taxes on owner-occupied housing, and payroll taxes. They do not include sales or excise taxes.

As shown in the table, the average after-tax income of elderly individuals is exceeded only by the average after-tax income of households headed by individuals ages 50 to 64. The amount of taxes paid as a percent of income (per household member) ranged in 1985 from 13.8 percent of income in households headed by someone ages 65 or older to 24.6 percent of income in households where the head was ages 45 to 49. In analyzing data on income per household member across different family types, it should be noted that most households headed by someone ages 65 or over are one- or two-member households; thus, housing consumes a greater proportion of the income of any one member of the household.

TABLE 16.—MEAN REAL INCOME BEFORE AND AFTER TAX PER HOUSEHOLD MEMBER, 1980 AND 1985

	1980 [1] income per household member		Taxes as a percent of income	1985 income per household member		Taxes as a percent of income	After tax percent change 1980–85
	Before taxes	After taxes		Before taxes	After taxes		
Age of households:							
15–24	8,260	6,726	18.6	7,681	6,296	18.0	−6.4
25–29	9,420	7,351	22.0	9,723	7,621	21.6	3.7
30–34	9,101	6,957	23.6	9,738	7,507	22.9	7.9
35–39	9,126	6,851	24.9	10,083	7,651	24.1	11.7
40–44	9,526	7,135	25.1	10,861	8,212	24.4	15.1
45–49	10,648	7,940	25.4	12,107	9,130	24.6	15.0
50–54	11,666	8,679	25.6	13,029	9,848	24.4	13.5
55–59	13,339	9,886	25.9	13,525	10,244	24.3	3.6
60–64	12,588	9,695	23.0	13,392	10,404	22.3	7.3
65 and over	9,456	8,223	13.0	10,622	9,152	13.8	11.3
All households	10,078	7,786	22.7	10,884	8,480	22.1	8.9

[1] In 1985 dollars.

Source: Bureau of the Census Series P–23, After Tax Money Income Estimates of Households; No. 126, Table I; No. 151, Table 1.

HOUSING ARRANGEMENTS OF THE ELDERLY

Table 17 shows housing tenure for poor and nonpoor aged families and unrelated individuals. The table shows that the majority of poor families with an aged member (74 percent) and aged poor unrelated individuals (51 percent) owned their own home or lived with relatives in an owner occupied unit. In comparison, 87 percent of aged nonpoor families and 65 percent of aged nonpoor unrelated individuals owned their own home. About one in five (19.6 percent) poor aged unrelated individuals reported living in publicly supported housing (either public housing or rent subsidized housing). About 9 percent of aged nonpoor unrelated individuals lived in publicly supported housing.

TABLE 17.—HOUSING TENURE OF AGED, FAMILIES, AND UNRELATED INDIVIDUALS BY FAMILY TYPE AND POVERTY STATUS, 1986

	Total (in thousands)	Percent of total				
		Own housing	No cash rent	Rent housing		
				Total	Publicly supported	Not publicly supported
Any member age 65 or over:						
In families:						
Total	12,101	86.2	1.3	12.5	1.8	10.8
Poor	825	74.1	2.6	23.3	7.1	16.2
Nonpoor	11,275	87.0	1.2	11.8	1.4	10.4
Unrelated individuals:						
Total	9,184	61.4	3.4	35.3	11.6	23.6
Poor	2,311	51.3	5.7	43.0	19.6	23.4
Nonpoor	6,873	64.7	2.6	32.6	8.9	23.7

Source: March 1987 Current Population Survey (CPS). Table prepared by CRS.

FEDERAL SPENDING FOR THE ELDERLY [3]

Past growth in the size of the elderly population—and decisions to cover an increasing share of their needs through public programs—have significantly altered the shape of the Federal budget. As shown in table 18, between 1965 and 1985 spending for the elderly under major Federal transfer programs grew from about $63 billion to nearly $260 billion in constant 1985 dollars, or from about $3,400 per elderly person to more than $9,000 in constant dollars. During that period, spending for the elderly rose from 16 percent to 27 percent of all Federal outlays, or from about one-third to nearly one-half of all outlays for domestic programs—that is, spending other than for defense and net interest payments. Relative to the economy, Federal spending for the elderly grew from 2.8 percent to 6.6 percent of the gross national product (GNP).

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[3] Source: Statement of Rudolph Penner, CBO, before the Subcommittee on Economic Resources, Competitiveness, and Security Economics, July 31, 1986.

Tax benefits also play a major role in affecting the income available to the elderly after retirement, as demonstrated in the next subsection.

TABLE 18.—ESTIMATED FEDERAL SPENDING FOR THE ELDERLY UNDER SELECTED PROGRAMS: FISCAL YEARS 1965–1985

[In billions of dollars]

	1965	1971	1975	1980	1985
Social Security	(1)	27.1	51.8	81.2	140.4
Railroad retirement	(1)	1.7	2.8	3.6	4.7
Federal civilian retirement	(1)	2.3	5.5	7.8	13.7
Military retirement	(1)	.7	1.1	1.8	4.3
Benefits for coal miners [2]	(1)	.1	.2	1.3	1.5
Supplementary security income	(1)	[3] 1.4	1.8	2.3	3.2
Veterans pensions [4]	(1)	.9	1.5	3.3	5.4
Medicare	(1)	7.5	12.8	29.3	61.4
Medicaid	(1)	1.9	2.6	4.7	8.5
Food stamps [5]	(1)	.2	1.0	.5	.6
Housing assistance	(1)	.2	.4	2.3	[6] 4.5
Other [7]	(1)	NA	NA	6.1	10.3
Total	18.8	44.0	81.3	144.2	258.6
Total in 1985 dollars	62.6	113.1	158.5	191.0	258.6
Federal Spending for the Elderly Relative to Total Federal Outlays, the Size of the Elderly Population, and GNP					
Spending for the elderly:					
Per aged person, in 1985 dollars	3,390	5,500	6,980	7,430	9,060
As a percent of total Federal outlays	15.9	20.9	24.5	24.4	27.3
As a percent of total Federal outlays, excluding defense and net interest	31.9	37.8	36.5	35.7	45.8
As a percent of GNP	2.8	4.2	5.3	5.4	6.6

[1] Estimated total spending for the elderly in 1965 was taken from a source that did not report spending separately by program.

[2] Prior to 1980, represents benefits for miners' widows only.

[3] Represents grants to states to aid the aged, blind, and disabled.

[4] Includes other veterans' compensation for aged beginning in 1980.

[5] Includes nutrition assistance to Puerto Rico.

[6] Adjusted to eliminate outlays resulting from changing the financing procedures for public housing.

[7] Includes, among other items, Administration on Aging programs, National Institute on Aging spending, housing loans for the elderly, and energy assistance.

NA—Not available.

Sources: Statement of Rudolph Penner, CBO, before the Subcommittee on Economic Resources, Competitiveness, and Security Economics, July 31, 1986. Figures for 1971–1985 from 1986 Statistical Abstract of the United States; figures for 1965 from R. Clark and J. Menefee, "Federal Expenditures for the Elderly: Past and Future," The Gerontologist, April 1981.

Notes: Reported spending includes only Federal outlays directed toward the elderly. Figures do not include Federal outlays benefiting younger people or spending by State and local governments.

Details may not add to totals because of rounding.

TAX TREATMENT OF THE ELDERLY

Present law includes a number of provisions that have the effect of reducing or eliminating the burden of Federal income tax on individuals who are elderly, disabled, or unable to work on account of injury or layoff. Some of these special provisions are targeted to lower income taxpayers; others reduce taxes for all taxpayers.

Prior law

Before 1987, the taxes of the elderly were reduced relative to that of other taxpayers through several mechanisms: the extra personal exemption, the credit for the elderly and disabled, the exclusion of Medicare benefits, and the nontaxation of Social Security benefits for individuals with adjusted gross incomes below certain thresholds.

Generally, prior law provided a personal exemption, worth $1,080 in 1986, to every taxpayer, the taxpayer's spouse, and each of the taxpayer's dependents. An additional personal exemption was provided for an individual who was age 65 or older, or who was blind. An individual who was both age 65 and blind was entitled to claim two additional personal exemptions. Thus, an individual age 65 or older was entitled to a personal exemption in 1986 of $2,160; an individual who was both elderly and blind, an exemption of $3,240.

Prior law also provided a nonrefundable income tax credit for individuals age 65 or older or those who retired on permanent or total disability. This mechanism remains unchanged in present law, and is described more fully below. In addition, prior law (as does present law) exempted Social Security benefits from taxation unless the individual's adjusted gross income exceeded $25,000 in the case of a single individual, and $32,000 in the case of married taxpayers filing jointly. See section 12 for a more complete explanation.

Present law

The Tax Reform Act of 1986 expanded the size of the personal exemption for every taxpayer to $1,900 in 1987, $1,950 in 1988, and $2,000 in 1989. After 1989, the personal exemption is indexed, so it is scheduled to increase with increases in the Consumer Price Index. (After 1987, the personal exemption is phased out for very high income taxpayers).

As a result of the act, the elderly are not entitled to an extra personal exemption. Instead, present law provides for every person who is blind or elderly an addition to the individual's standard deduction. The additional amount is $600 for each married individual who is blind or elderly, and $750 for each unmarried blind or elderly individual. A person who is both blind and elderly is entitled to an addition to the individual's standard deduction of $1,200 if married filing jointly, and $1,500 if single. After 1987, these amounts are indexed to increases in the Consumer Price Index.

As under prior law, present law provides a nonrefundable income tax credit for individuals who are age 65 or over, or who have retired on permanent and total disability. For this purpose the definition of disability is identical to the standard used to determine eligibility for Social Security disability benefits. This credit is designed to provide tax benefits to individuals who receive only taxable retirement or disability income, or who receive a combination of taxable retirement or disability income plus Social Security benefits, that are generally comparable to the tax benefits provided to individuals who receive only Social Security benefits.

The credit equals 15 percent of an amount which equals an initial base amount ($5,000 for individual filers), as specified in the statute, that is then reduced by the amount of certain tax-free income received by the taxpayer and by one-half of the taxpayer's AGI exceeding a specified threshold. The credit is not indexed to the Consumer Price Index.

Like prior law, present law exempts from taxation the Social Security benefits of individuals whose Adjusted Gross Income is below certain thresholds ($25,000 for unmarried individuals, $32,000 for married couples filing jointly). These thresholds are not indexed to the Consumer Price Index.

As a result of the additional standard deduction, the credit, and the tax exemption for certain Social Security benefits, the tax threshold for elderly persons (that is, the income level at which a positive tax liability is incurred) is well above the poverty level. Indeed, as table 20 shows, the combination of these special tax provisions ensures that 57.4 percent of elderly individuals have no Federal income tax liability in 1989. For example, the income tax threshold of a single elderly individual with $5,000 of Social Security income is $5,911, and for an elderly married couple filing jointly is $11,976 (see table 19.)

In 1987 the average annual benefit of a retired worker was $5,769; the average annual benefit of a retired worker and spouse was $10,047.

TABLE 19.—TAX THRESHOLDS FOR ELDERLY INDIVIDUALS,[1] 1988–91

Year and filing status	Amount of social security income			
	Zero	$2,500	$5,000	$7,500
1988:				
Single	9,633	7,967	5,700	5,700
Joint	15,067	13,400	11,733	10,100
1989:				
Single	9,774	8,107	5,911	5,911
Joint	15,310	13,643	11,976	10,465
1990:				
Single	9,970	8,303	6,205	6,205
Joint	15,657	13,990	12,323	10,986
1991:				
Single	10,162	8,495	6,493	6,493
Joint	15,997	14,330	12,663	11,496

[1] Tax threshold is amount of adjusted gross income (excluding social security) at which tax liability begins. Table assumes taxpayers are 65 or older, are not blind, and receive no excludable disability benefit, annuity, or pension income other than social security income.

TABLE 20.—DISTRIBUTION OF ELDERLY BY INCOME CLASS, 1989

Income [1] class (in thousands of current dollars)	Number of elderly individuals (thousands)	Percentage of elderly
Taxable returns:		
Below $10	4	0.0
$10 to $20	1,801	5.8
$20 to $30	3,031	9.8
$30 to $40	3,175	10.2
$40 to $50	1,848	6.0
$50 to $75	1,905	6.1
$75 to $100	660	2.1
$100 to $200	543	1.8
$200 and over	241	.8
Nontaxable	17,817	57.4
Total	31,024	100.0

[1] The income concept used to place tax returns into income classes is adjusted gross income plus (1) tax exempt interest, (2) employer contributions for health plans and life insurance, (3) inside build-up on life insurance, (4) workers' compensation, (5) nontaxable Social Security benefits, (6) contributions to individual retirement accounts, (7) the minimum tax preferences, and (8) net losses, in excess of minimum tax preferences, from passive business activities.

Source: Joint Committee on Taxation.

ECONOMIC STATUS OF THE NEWLY RETIRED

Tables 21 and 22 provide information on the economic status of the newly retired. Data for these tables are taken from the Social Security Administration's New Beneficiary Survey of 1982. New retirees in 1982 had their prime earning years during the relatively affluent decades of the 1950's, 1960's and 1970's. Compared with those who retired in the 1960's and 1970's, the 1982 retires have enjoyed higher earnings which has allowed them to save more and retire earlier. Generally they have experienced greater pension coverage and report a better general level of health.

Table 21 shows the percent of new retired workers receiving income from 4 major income sources and the median monthly income from those sources for those receiving such income. A relatively high proportion of the new retirees had income from pensions (56 percent of the married men and their wives and 42 percent of the unmarried persons). A large fraction had income from earnings (44 percent of the married men and their wives and 27 percent of the unmarried persons.)[4]

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[4] For further information on the incomes of new retirees see the January, May, and July 1985 issues of the Social Security Bulletin.

TABLE 21.—1982 MONTHLY INCOME FROM MAJOR INCOME SOURCES FOR PERSONS WHO FIRST RECEIVED SOCIAL SECURITY RETIRED WORKER BENEFITS BETWEEN JUNE 1980 AND MAY 1981

	Percent receiving	Median monthly income (for recipients)
Married men and their wives:		
Social Security	98.3	$646
Earnings	43.7	617
Pensions	55.8	490
Asset income	83.0	180
Total income	100.0	1,511
Total number (thousands)	580.0	
Unmarried men and women:		
Social Security	97.0	421
Earnings	27.0	392
Pensions	42.4	291
Asset income	69.1	99
Total income	100.0	775
Total number (thousands)	295.9	

Source: Social Security Administration's New Beneficiary Survey, 1982.

Table 22 shows the percent of retired workers with home equity and with financial assets, and their median values. About 9 out of 10 of the married couples had these assets. Fewer, though still a large majority, of the unmarried retirees had some financial assets. Just under half of unmarried men and nearly 60 percent of the unmarried women had equity in an owned home. Home equity provided the major portion of the asset portfolios of retirees. The median value of the total portfolios, when home equity was excluded, was $20,000 for married men, $15,700 for married women, $3,500 for unmarried men, and $5,100 for unmarried women.

TABLE 22.—ASSET HOLDINGS IN 1982 OF RETIRED-WORKER BENEFICIARIES WHO FIRST RECEIVED A BENEFIT BETWEEN JUNE 1980 AND MAY 1981

	Married retirees and their spouses		Unmarried retirees	
	Men	Women	Men	Women
Home equity:				
Percent with any	87	88	48	58
Median amount	$48,000	$45,000	$35,000	$38,000
Financial assets:				
Percent with any	93	93	76	86
Median amount	$18,000	$14,800	$8,800	$7,500
Median value of asset portfolio for all:				
Including home equity	$68,300	$64,700	$17,000	$30,100
Excluding home equity	20,000	15,700	3,500	5,100

Source: Sally R. Sherman, "Assets of New Retired-Worker Beneficiaries: Findings From the New Beneficiary Survey," Social Security Bulletin, July 1985, Vol. 48, No. 7.

Tables 23 and 24 report on the health status of new retirees. About two-thirds of the people receiving a first Social Security retired workers benefit between June 1980 and May 1981 reported in late 1982 that they had no health related work limitation. Approximately half the remaining beneficiaries (18 percent of the total) reported they were unable to work at all. Those receiving their first Social Security benefit at age 62 were more likely to report on inability to work than those first receiving them at older ages. Since 1969, the proportion of newly retired men reporting no health related work limitations has increased by a third (from 45 percent in 1969 to 63 percent in 1982). However, the proportion reporting they are unable to work at all has remained constant at 18 percent over this period. 1969 data on the health of women retired workers are not available.[5]

TABLE 23.—PERCENT OF NEW RETIRED WORKER BENEFICIARIES REPORTING HEALTH RELATED WORK LIMITATIONS BY AGE AT FIRST BENEFIT RECEIPT, 1982

	Men			Women		
	Total	Age 62	Age 63 or older	Total	Age 62	Age 63 or older
Total percent	100	100	100	100	100	100
No work limitation	64	57	70	69	66	73
Some work limitation	18	21	16	13	14	12
Unable to work	18	22	14	18	20	15

Source: Social Security Administration's New Beneficiary Survey, 1982.

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[5] For further information on the health status of new retirees see Packard, Social Security Bulletin, February 1985.

TABLE 24.—PERCENT OF NEWLY RETIRED MEN REPORTING HEALTH RELATED WORK LIMITATIONS BY AGE AT FIRST BENEFIT RECEIPT, 1969 AND 1982

	1969			1982		
	Total	Age 62	Age 63 to 64	Total	Age 62	Age 63 to 64
Total percent	100	100	100	100	100	100
No work limitation	45	39	53	63	57	69
Some work limitation	31	33	28	19	21	17
Unable to work	19	22	14	18	22	13
Nonresponse	5	7	4	0	0	0

Sources: Social Security Administration's Survey of Newly Entitled Beneficiaries, 1968–70 and New Beneficiary Survey, 1982.

ECONOMIC STATUS OF NEW DISABLED-WORKER BENEFICIARIES

Tables 25 and 26 provide information on the economic status of the newly disabled. The data are from The New Beneficiary Survey, conducted by the Social Security Administration in 1982. For the disabled, income includes that received by a spouse and by children under age 19, if present in the household.

Table 25 shows the percent of disabled-worker beneficiaries who received income from 4 major income sources—social security, earnings, pensions and assets. Few of the unmarried disabled had any earnings (7 percent), whereas the presence of a spouse accounts for the high proportions (44 percent and 54 percent) of the married disabled who had earnings. Income from assets was received by about 60 percent of the married couples, but by less than 30 percent of the unmarried men and less than 40 percent of the unmarried women. The median total monthly income was about $1,300 for the couples and just under $500 for the unmarried. These are roughly half the median total incomes of couples and unmarried persons aged 25–64 in the total noninstitutionalized population.

Table 26 shows the value of the assets held by the disabled and their spouses, if present. Aside from equity in an owned home, the disabled did not have large asset holdings. Older married men, the largest subgroup among the disabled, were the most well-off, though when home equity was excluded, the median value of their asset portfolio was $3,600.

TABLE 25.—SOURCES OF INCOME AND MEDIAN TOTAL MONTHLY INCOME FOR DISABLED-WORKER BENEFICIARIES [1] THEIR SPOUSES AND CHILDREN UNDER AGE 19, BY SEX AND MARITAL STATUS OF THE DISABLED WORKER, 1982

	Married men	Married women	Unmarried men	Unmarried women
Percent receiving:				
Social security	99.5	99.6	98.9	99.2
Earnings	43.6	53.9	6.8	5.7
Pensions	42.1	37.5	18.4	23.4
Asset income	60.3	59.3	28.9	39.1
Median monthly income	$1,230	$1,360	$490	$460

[1] For beneficiaries who first received a benefit between July 1980 and June 1981.

Source: Michael D. Packard, "Income of New Disabled-Worker Beneficiaries and Their Families: Findings from the New Beneficiary Survey," Social Security Bulletin, March 1987, Vol. 50, No. 3.

TABLE 26.—ASSET HOLDINGS IN 1982 OF DISABLED-WORKER BENEFICIARIES WHO FIRST RECEIVED BENEFITS BETWEEN JULY 1980 AND JUNE 1981

	Disabled men		Disabled women	
	Under 55	55–64	Under 55	55–64
MARRIED DISABLED WORKERS AND THEIR SPOUSES				
Home equity:				
Percent with any	75	83	78	85
Median amount	$28,000	$38,000	$29,000	$35,000
Financial assets:				
Percent with any	77	86	78	84
Median amount	$700	$5,000	$1,100	$4,000
Median value of asset portfolio for all:				
Including home equity	$23,000	$41,000	$25,800	$37,000
Excluding home equity	300	3,600	700	2,100
UNMARRIED DISABLED WORKERS				
Home equity:				
Percent with any	16	30	31	48
Median amount	$15,000	$28,000	$23,000	$25,000
Financial assets:				
Percent with any	50	57	60	73
Median amount	$200	$800	$200	$600
Median value of asset portfolio for all:				
Including home equity		$200	$200	$6,300
Excluding home equity				200

Source: Martynas A. Ycas. "Asset Holdings of the Newly Disabled: Findings from the New Beneficiary Survey," Social Security Bulletin, December 1986, Vol. 49, No. 12.

APPENDIX I. POVERTY, INCOME, AND WEALTH STATISTICS [1]

This appendix presents statistics which describe the poverty, income and wealth status of individuals and/or families. It covers the following topics:

- —measuring poverty, trends in the overall poverty rate, poverty rates for individuals in selected subgroups, poverty rates in rural versus urban areas, poverty rates by family type;
- —antipoverty effectiveness of various cash, near-cash, and noncash income sources for all individuals in: families or living alone, families with children, female-headed families with children, married-couple families with children, and families with all members age 65 and over;
- —explanations for increases in poverty between 1979 and 1986;
- —measuring family income, trends in family income, trends in income inequality among family types, trends in income distribution within family types; and
- —total household net worth, home equity, net worth from sources other than home equity.

POVERTY STATISTICS

MEASURING POVERTY

When the Federal Government began measuring poverty in the early 1960's, the continued existence of poor people in a time of the "Affluent Society" seemed anomalous. Official concern soon translated into efforts to measure the size of the poverty population, and the search began for programmatic ways to alleviate poverty. The first rough estimates of the incidence of poverty were based on survey data indicating that families generally spent about one-third of their income for food. A poverty level income was then calculated by using as a yardstick the amount of money necessary to purchase the lowest cost "nutritionally adequate" diet calculated by the Department of Agriculture (roughly equivalent to the current Thrifty Food Plan). This price tag was multiplied by 3 to produce a poverty threshold. This procedure assumed, then, that if a family did not have enough income to buy the lowest cost nutritionally adequate diet, and twice that amount to buy other goods and services, it was "poor." Appropriate adjustments were made for the size of the family, the sex of the family head, and for whether the family lived on the farm or not. Farm families were assumed to need less cash income because their needs could be met partially by farm products, particularly food. The adjustments for sex of the family head and for farm-nonfarm residence were abolished in 1981. Policy officials made one change to the basic approach for calculating the poverty threshold in 1969. The current poverty threshold is established each year simply by increasing the previous year's threshold by the change in the Consumer Price Index (CPI), rather than multiplying the cost of the Thrifty Food Plan by 3. The poverty thresholds for selected years are shown in table 1.

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[1] See Appendix G and Appendix H for additional poverty and income data related to individuals in families with children and the elderly.

Note that the tables in this subsection provide poverty data calculated using the official census definition of poverty. The census definition of poverty has remained fairly standard over time and is useful for measuring progress against poverty. Under this definition, poverty is determined by comparing pretax cash income with the poverty threshold.

It should be noted that the Census Bureau revised its method of estimating the poverty threshold four times—in 1966, 1974, 1979, and 1981. These revisions changed the estimate of the poverty rate. The first two revisions slightly reduced the estimated number of poor, while the more recent revisions slightly increased the number. In 1984, the Census Bureau also revised its method of imputing missing values for interest income, which lowered the estimated poverty rate slightly.

TABLE 1.—WEIGHTED AVERAGE POVERTY THRESHOLDS FOR NONFARM FAMILIES OF SPECIFIED SIZE, SELECTED YEARS, 1959–87

Calendar year	Unrelated individuals			Families of 2 or more persons							
				2 persons			3 persons	4 persons	5 persons	6 persons	7 persons or more
	All ages	Under age 65	Aged 65 or older	All ages	Head under age 65	Head aged 65 or older					
1959	$1,467	$1,503	$1,397	$1,894	$1,952	$1,761	$2,324	$2,973	$3,506	$3,944	$4,849
1960	1,490	1,526	1,418	1,924	1,982	1,788	2,359	3,022	3,560	4,002	4,921
1965	1,582	1,626	1,512	2,048	2,114	1,906	2,514	3,223	3,797	4,264	5,248
1970	1,954	2,010	1,861	2,525	2,604	2,348	3,099	3,968	4,680	5,260	6,468
1975	2,724	1,797	2,581	3,506	3,617	3,257	4,293	5,500	6,499	7,316	9,022
1976	2,884	2,959	2,730	3,711	3,826	3,445	4,540	5,815	6,876	7,760	9,588
1977	3,075	3,152	2,906	3,951	4,072	3,666	4,833	6,191	7,320	8,261	10,216
1978	3,311	3,392	3,127	4,249	4,383	3,944	5,201	6,662	7,880	8,891	11,002
1979	3,689	3,778	3,479	4,725	4,878	4,390	5,784	7,412	8,775	9,914	12,280
1980	4,190	4,290	3,949	5,363	5,537	4,983	6,565	8,414	9,966	11,269	[1]12,761
1981	4,620	4,729	4,359	5,917	6,111	5,498	7,250	9,287	11,007	12,449	[1]14,110
1982	4,901	5,019	4,626	6,281	6,487	5,836	7,693	9,862	11,684	13,207	[1]15,036
1983	5,061	5,180	4,775	6,483	6,697	6,023	7,938	10,178	12,049	13,630	[1]15,500
1984	5,278	5,400	4,979	6,762	6,983	6,282	8,277	10,609	12,566	14,207	[1]16,096
1985	5,469	5,593	5,156	6,998	7,231	6,503	8,573	10,989	13,007	14,696	[1]16,656
1986	5,572	5,702	5,255	7,138	7,372	6,630	8,737	11,203	13,259	14,986	[1]17,049
1987 (est.)	5,776	5,910	5,447	7,399	7,641	6,872	9,056	11,612	13,743	15,534	[1]17,672

[1] Poverty threshold for 7 persons, not 7 persons or more.

Source: Bureau of the Census, technical papers.

TRENDS IN THE OVERALL POVERTY RATE [2]

Table 2, which covers the time period 1959 through 1986, presents historical poverty date.

In the late 1950's, the overall poverty rate for individuals in the United States was 22 percent, representing 39.5 million poor persons. Between 1959 and 1969, the poverty rate declined dramatically and steadily to 12.1 percent. As a result of a sluggish economy, the rate increased slightly to 12.5 percent by 1971. In 1972 and 1973, however, it began to decrease again. The lowest rate over the entire 24-year period occurred in 1973, when the poverty rate was 11.1 percent. At that time roughly 23 million people were poor, 42 percent less than were poor in 1959.

The poverty rate increased in 1974 and 1975 to 12.3 percent, and remained steady near 11.5 percent through 1979. After 1979, however, the poverty rate rose rather quickly, reaching 15.2 percent in 1983. In 1986, the last year for which data are available, the poverty rate was 13.6 percent and 32.4 million people were poor.

POVERTY RATES FOR INDIVIDUALS IN SELECTED SUBGROUPS OF THE POPULATION

As table 2 also illustrates, there are substantial differences between the overall poverty rate and the poverty rates of individuals in certain demographic subgroups. Most notably, blacks, individuals in female-headed households, and Hispanics have poverty rates that greatly exceed the average. The poverty rates for blacks and individuals in female-headed households remained above 30 percent over the 1959 through 1986 period. The poverty rate for Hispanics has remained near 30 percent during the 1980's. The poverty rate for children also exceeds the average rate; it remained above 14 percent during the 1959 through 1986 period and was 19.8 percent in 1986. The poverty rate for the aged, which exceeded the overall poverty rate in 1959, fell below the overall poverty rate in 1982. It was 12.4 percent in 1986. The poverty rate for whites was below the overall poverty rate throughout the entire 1959–1986 period. It was 11.0 percent in 1986.

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[2] All poverty trend information is based upon published Census Bureau data contained in "Money Income and Poverty Status of Families: 1978," p–60. No. 124; "Money Income and Poverty Status of Families: 1982," p–60, No. 140; "Money Income and Poverty Status of Families and Persons in the United States: 1983," p–60. No. 145; "Money Income and Poverty Status of Families and Persons in the United States: 1984," p–60. No. 149; "Money Income and Poverty Status of Families: 1985," p–60. No. 154; and "Money Income and Poverty Status of Families: 1986," p–60, No. 157. All figures for children are for related children under 18 in families. These figures may differ with other parts of this report which provide a more refined breakdown of this age category. Data for blacks, the aged, and nonaged population were not available for the years 1961 to 1965.

TABLE 2.—NUMBER OF PERSONS IN POVERTY AND POVERTY RATE FOR INDIVIDUALS IN SELECTED DEMOGRAPHIC GROUPS, 1959–1986

Year	Overall	Aged	Children [1]	Individuals in female-headed families	Blacks	Hispanic origin [2]	Whites
Number below poverty (thousands)							
1959	39,490	5,481	17,208	10,390	9,927	NA	28,484
1960	39,851	NA	17,288	10,663	NA	NA	28,309
1965	33,185	NA	14,388	11,058	NA	NA	22,496
1966	28,510	5,114	12,146	10,250	8,867	NA	19,290
1967	27,769	5,388	11,427	10,591	8,486	NA	18,983
1968	25,389	4,632	10,739	10,364	7,616	NA	17,395
1969	24,147	4,787	9,501	10,412	7,095	NA	16,659
1970	25,420	4,793	10,235	11,154	7,548	NA	17,484
1971	25,559	4,273	10,344	11,409	7,396	NA	17,780
1972	24,460	3,738	10,082	11,587	7,710	2,414	16,203
1973	22,973	3,354	9,453	11,357	7,388	2,366	15,142
1974	23,370	3,085	9,967	11,469	7,182	2,575	15,736
1975	25,877	3,317	10,882	12,268	7,545	2,991	17,770
1976	24,975	3,313	10,081	12,586	7,595	2,783	16,713
1977	24,720	3,177	10,028	12,624	7,726	2,700	16,416
1978	24,497	3,233	9,722	12,880	7,625	2,607	16,259
1979	26,072	3,682	9,993	13,503	8,050	2,921	17,214
1980	29,272	3,871	11,114	14,649	8,579	3,491	19,699
1981	31,822	3,853	12,068	15,738	9,173	3,713	21,553
1982	34,398	3,751	13,139	16,336	9,697	4,301	23,517
1983	35,303	3,625	13,427	16,713	9,882	4,633	23,984
1984	33,700	3,330	12,929	16,440	9,490	4,806	22,955
1985	33,064	3,456	12,483	16,365	8,926	5,236	22,860
1986	32,370	3,477	12,257	16,926	8,983	5,117	22,183
Poverty rate (percent)							
1959	22.4	35.2	26.9	50.2	55.1	NA	18.1
1960	22.2	NA	26.5	49.5	NA	NA	17.8
1965	17.3	NA	20.7	46.0	NA	NA	13.3
1966	14.7	28.5	17.4	41.0	41.8	NA	11.3
1967	14.2	29.5	16.3	40.6	39.3	NA	11.0
1968	12.8	25.0	15.3	38.9	34.7	NA	10.0
1969	12.1	25.3	13.8	38.4	32.2	NA	9.5
1970	12.6	24.6	14.9	38.2	33.5	NA	9.9
1971	12.5	21.6	15.1	38.0	32.5	NA	9.9
1972	11.9	18.6	14.9	36.9	33.3	22.8	9.0
1973	11.1	16.3	14.2	34.9	31.4	21.9	8.4
1974	11.2	14.6	15.1	33.6	30.3	23.0	8.6
1975	12.3	15.3	16.8	34.6	31.3	26.9	9.7
1976	11.8	15.0	15.8	34.4	31.1	24.7	9.1
1977	11.6	14.1	16.0	32.8	31.3	22.4	8.9
1978	11.4	14.0	15.7	32.3	30.6	21.6	8.7
1979	11.7	15.2	16.0	32.0	31.0	21.8	9.0

TABLE 2.—NUMBER OF PERSONS IN POVERTY AND POVERTY RATE FOR INDIVIDUALS IN SELECTED DEMOGRAPHIC GROUPS, 1959–1986—Continued

Year	Overall	Aged	Children [1]	Individuals in female-headed families	Blacks	Hispanic origin [2]	Whites
1980	13.0	15.7	17.9	33.8	32.5	30.8	10.2
1981	14.0	15.3	19.5	35.2	34.2	26.5	11.1
1982	15.0	14.6	21.3	36.2	35.6	29.9	12.0
1983	15.2	13.8	21.8	35.6	35.7	28.0	12.1
1984	14.4	12.4	21.0	34.0	33.8	28.4	11.5
1985	14.0	12.6	20.1	33.5	31.3	29.0	11.4
1986	13.6	12.4	19.8	34.2	31.1	27.3	11.0

[1] Related children under 18 in families.

[2] Hispanic origin may be of any race.

NA—Not available.

Source: Bureau of the Census, Technical Paper 56, table 1; series P–60: No. 134, table 15; No. 140, table 15; No. 145, table 15; No. 149, table 15; No. 152, table 1; No. 154, table 16; No. 157, tables 15 and 16.

GEOGRAPHIC DIFFERENCES IN POVERTY

Poverty rates by State are provided in Appendix J. This section outlines rural/urban differences in poverty.[3] As table 3 shows, 1986 marked the first year that the nonmetro poverty rate (18.1 percent) equalled or exceeded the central city poverty rate (18.0 percent). Between 1978 and 1986, the poverty rate in nonmetro areas increased nearly twice as much as the rate in metro and central city areas.

Poverty rates were higher in rural areas than urban areas for every race classification in 1986. Table 4 shows that the poverty rate for whites living in nonmetro areas, 15.1 percent, was higher than the poverty rate of 14.0 percent for whites living in central cities. Hispanics had a poverty rate of 38.2 percent in nonmetro areas and 31.1 percent in central cities. For blacks, the rural/central city differences were even greater: the nonmetro poverty rate was 42.3 percent and the central city rate was 31.2 percent.

Differences between rural and urban area poverty are also apparent in the family composition and work status of the poor. The rural poor, more than the urban poor, tend to be comprised of families with two parents and with wage earners. As table 4 shows, in

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[3] The terms "urban" and "metro" are used synonymously to describe those areas designated by the Bureau of the Census as metropolitan statistical areas (MSA). The Census Bureau defines a metropolitan statistical area as "a geographic area consisting of a large population nucleus, together with adjacent communities which have a high degree of economic and social integration with that nucleus. The definitions specify a boundary around each large city so as to include most or all of its suburbs. Entire counties form the MSA building blocks, except in New England where cities and towns are used." (Bureau of the Census, U.S. Department of Commerce, Poverty in the United States: 1985, Series P–60, No. 158, October 1987, p. 159)

The terms "rural" and "nonmetro" are likewise used to describe those areas that the Census Bureau designates as being outside a metropolitan statistical area.

The term "central city" is used as defined by the Census Bureau to mean the largest city or cities in a metropolitan statistical area.

1985, two-thirds of the poor in nonmetro areas lived in two-parent families, whereas half of the poor in metro areas lived in such households. Further (and not shown in this table), of the nonmetro families whose incomes lie below the poverty line, more than two-thirds had at least one member working in 1983, and one-fourth had at least two members working. By contrast, in metro areas, approximately half of the families that were poor had one or more members working.[4]

TABLE 3.—PERSONS IN POVERTY AND POVERTY RATES IN NONMETRO AND METRO AREAS, 1978–1986

[Numbers in thousands]

	Nonmetro		Metro			
	Number	Percent	Total		Central cities only	
			Number	Percent	Number	Percent
1978	9,407	13.5	15,090	10.4	9,285	15.4
1979	9,937	13.8	16,135	10.7	9,720	15.7
1980	11,251	15.4	18,021	11.9	10,644	17.2
1981	12,475	17.0	19,347	12.6	11,231	18.0
1982	13,152	17.8	21,247	13.7	12,696	19.9
1983	13,516	18.3	21,750	13.8	12,872	19.8
1984	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
1985	9,789	18.3	23,274	12.7	14,177	19.0
1986	9,712	18.1	22,657	12.3	13,295	18.0
Percent change 1978–1986	3.2	34.1	50.1	18.3	43.2	16.9

N.A.—Not available.

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[4] Kenneth L. Deavers, Robert A. Hoppe, and Peggy J. Ross, "The Rural Poor: Policy Issues for the 1980's," Economic Research Service, U.S. Department of Agriculture, undated.

TABLE 4.—NUMBER AND PERCENT OF PERSONS IN POVERTY IN 1986 BY RACE AND COMPOSITION OF THE POVERTY POPULATION IN 1985 BY FAMILY TYPE

[Numbers in thousands]

	Nonmetro		Metro			
			Total		Central cities only	
	Number	Percent	Number	Percent	Number	Percent
1986						
All races	9,712	18.1	22,657	12.3	13,295	18.0
White	7,136	15.1	15,048	9.7	7,537	14.0
Black	2,245	42.3	6,738	28.6	5,132	31.2
Hispanic	552	38.2	4,565	26.4	3,125	31.1
1985						
Poor persons in families	7,721	100.0	18,008	100.0	10,929	100.0
In female-headed families	2,572	33.3	9,028	50.1	6,365	58.2
In all other families [1]	5,149	66.7	8,981	49.9	4,564	41.8

[1] The majority of this group is comprised of married couples (with or without children).

Source: Bureau of the Census, Money Income and Poverty Status of Families and Persons in the United States: 1986, Table 18.

COMPOSITION OF THE POVERTY POPULATION

The composition of the poverty population changes over time as both the relative size of the various subgroups of the population change and as the poverty rates of different subgroups change. Table 5 presents data on the composition of the poverty population, broken down by selected subgroups of the population for several years between 1959 and 1986.

TABLE 5.—COMPOSITION OF POVERTY POPULATION FOR SELECTED DEMOGRAPHIC GROUPS

[Percent of poverty population]

	1959	1966	1975	1982	1983	1984	1985	1986
Aged	13.9	17.9	12.8	10.9	10.5	9.9	10.5	10.7
Children	43.6	42.6	42.1	38.2	37.9	38.4	37.7	37.9
Nonaged adults	42.5	39.5	45.1	50.9	51.6	51.7	51.8	51.4
Individuals in female-headed families	26.3	36.0	47.4	47.5	47.4	48.8	49.5	52.3
Individuals in all other families	73.7	64.0	52.6	52.5	52.6	51.2	50.5	47.7
Blacks	25.1	31.1	29.2	28.2	27.8	28.2	27.0	27.8
Whites	72.1	67.7	68.7	68.4	68.1	68.1	69.1	68.5
Other races	2.8	1.2	2.1	3.4	4.1	3.7	3.9	3.7
Hispanic origin [1]	NA	NA	11.6	12.5	13.1	14.3	15.8	15.8

[1] Hispanic origin may be of any race.

Source: Estimates based on data from "Money Income and Poverty Status of Families and Persons in the United States: 1985," p. 60. No. 154 and No. 157.

POVERTY RATES FOR FAMILIES [5]

Table 5 presents poverty data for families and unrelated individuals (individuals living alone). Female-headed families with children and unrelated individuals are more likely to be poor than other families with children or families with aged members. In 1986, 47 percent of female-headed families with children were poor, compared with 8 percent of male-present families. Although only about 7 percent of all families with an aged member were poor, 25 percent of all aged unrelated individuals were poor. About 20 percent of nonaged unrelated individuals were poor.

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[5] Income figures reported in this subsection were derived from the March 1986 Current Population Survey (CPS) computer data tape. There is a tendency in surveys, such as the CPS, for respondents to underreport their incomes by both source and amount. Reporting of income from earnings is usually more accurate than the reporting of income from other sources. In general, CPS estimates of amounts or numbers of recipients of various cash and noncash transfer programs tend to be lower than administrative program totals. As a result, the data are a better reflection of general trends and patterns than of absolute numbers with income from a particular source, or the amount received.

Unrelated subfamilies are included as families in this analysis. The Census Bureau excludes such families from its poverty counts.

TABLE 6.—POVERTY RATES BY FAMILY TYPE, 1982–86, AND PERCENTAGE OF FAMILIES AND UNRELATED INDIVIDUALS BY RATIO OF TOTAL INCOME TO POVERTY THRESHOLD,[1] 1986

	Poverty rate, 1982–86					Ratio of total income to poverty threshold, 1986							1986 Total (in thousands)
	1982	1983	1984	1985	1986	Under 0.50	0.50 to 0.99	1.00 to 1.24	1.25 to 1.49	1.50 to 1.99	2.00 to 2.99	3.00 and over	
Total:													
Families	12.5	12.6	11.9	11.6	11.2	4.5	6.8	3.8	4.1	9.2	19.1	52.5	65,057
Unrelated individuals	23.1	23.4	21.8	21.4	21.6	8.3	13.3	8.2	6.3	10.9	17.0	36.0	31,679
No members age 65 or over:													
Families	13.3	13.5	13.0	12.7	12.3	5.2	7.1	3.6	3.8	8.6	18.2	53.5	52,957
Unrelated individuals	21.4	22.1	20.9	19.8	20.2	10.3	9.9	5.2	4.4	9.8	17.6	42.7	22,495
Any member age 65 or over:													
Families	9.0	8.8	7.2	7.1	6.8	1.4	5.4	4.6	5.5	11.9	23.0	48.2	12,101
Unrelated individuals	27.1	26.5	24.2	25.6	25.2	3.6	21.6	15.4	10.8	13.7	15.5	19.5	9,184
Families with children:													
Female headed family, no husband present	48.2	47.8	46.5	46.0	46.9	22.8	24.1	7.7	5.7	11.6	15.8	12.4	7,497
Male present families	10.2	10.5	9.8	9.3	8.5	2.6	5.9	3.9	4.5	10.2	22.8	50.1	26,770

[1] Based on census ("Orshansky") poverty levels.

Source: March Current Population Survey for selected years. Table prepared by CRS.

ANTIPOVERTY EFFECTIVENESS OF VARIOUS CASH, NEAR-CASH AND NONCASH INCOME SOURCES

As shown earlier in Appendix G and Appendix H, families and individuals differ markedly by the combinations of income upon which they rely for support. This section explores the effectiveness of various income sources in addressing poverty.

One way of assessing the antipoverty effectiveness of various income sources is to estimate the number of persons who would be counted as poor if a particular source of income were not received. The additional number of persons that are counted as poor provides an estimate of the number of people lifted out of poverty by a particular income source. For example, the effect of Social Security upon poverty can be seen by comparing the number who would be counted as poor if they did not receive Social Security with the number of poor remaining after Social Security income is counted.

A second way of assessing the effectiveness of various income sources upon poverty is to estimate the degree to which those sources reduce the gap between a poor family's income and the poverty threshold. This concept is sometimes known as the "poverty gap" or the "poverty income deficit." A cash transfer program which is highly targeted on the poor may do little to eliminate poverty—that is, to reduce the number who are counted as poor—but such a program may still have a very real impact by reducing the degree of poverty as viewed in terms of the poverty gap.

Tables 7 through 11 examine the antipoverty effectiveness of cash and noncash transfers from 1979 to 1986. These tables were prepared by the Congressional Budget Office using Census Bureau data and present information for all individuals in: families or living alone (table 7); families with related children less than 18 (table 8); families with an unmarried head and related children less than 18 (table 9); married-couple families with related children less than 18 (table 10); and families with all members ages 65 or older (table 11).

All statistics are based on Current Population Survey (CPS) data for the relevant year, unadjusted for possible underreporting. Asset income data have been adjusted for 1979 through 1983, however, to make them comparable to 1984, 1985 and 1986 data. This adjustment involved applying a more detailed methodology to impute asset income to people who reported receiving asset income but did not report the amount received. The effect of the changes is to increase incomes, particularly for the elderly. For the entire population, the poverty rate is reduced by about 0.1 percentage point in each year, 1979 through 1983. It was not possible, however, to adjust the data from earlier years to reflect the other change made in 1984, the revised weighting of persons of Hispanic origin.

Federal personal income taxes and Social Security payroll taxes were estimated with a microsimulation model using tax schedules and laws in effect in each year. In order to make taxes consistent with the incomes reported in the CPS, no adjustments were made for CPS underreporting and taxes were not estimated for capital gains or other taxable income not reported in the CPS. Statistics of Income (SOI) data were used to assign itemized deductions and Individual Retirement Account (IRA) contributions to tax filing units, while child care expenses were estimated based on data from the 1979 Panel Study of Income Dynamics (PSID). Payroll tax estimates were based on self-employment income and wages and salaries of all workers except Federal, railroad, and some state employees.

All valuations of in-kind transfers are those estimated by the Bureau of the Census using a *market value* valuation technique.[6] The market value generally attempts to measure the private market cost of benefits provided in-kind. Food stamps are assigned their value, while school lunches are assigned the average amount of Federal subsidy per child. Housing assistance is valued as the difference between the estimated market rent (based on the American Housing Survey) and the reduced rent paid by subsidized households.

Poverty under six different income concepts is measured. "Cash income before transfers" is all cash income prior to any benefits from government programs. This would include all earnings, pension income, income from savings, self-employment income, etc. "Plus social insurance" adds to cash income all benefits from social insurance (except Social Security) programs, such as workers' compensation and unemployment compensation. "Plus Social Security" adds to cash income and social insurance income benefits from the Social Security programs. "Plus means-tested cash transfers" adds to cash income and social insurance income all means-tested transfer income such as aid to families with dependent children, supplemental security income, and general assistance. "Plus food and housing" adds to cash, social insurance and means-tested cash income all means-tested in-kind transfers received for food and housing. This would include food stamps, housing programs and school lunch programs. Benefits are valued using the *market value* method. "Less Federal taxes" subtracts from income Federal income taxes and the employee portion of Federal payroll taxes.

Table 7 shows that before any governmental transfers, 49.7 million individuals would have been poor in 1986. With social insurance benefits, 34.5 million individuals are poor; a reduction of 15.2 million. Means-tested cash and in-kind transfers reduce the poverty count by an additional 5.5 million individuals.

In 1979, 15.0 percent of individuals were removed from poverty due to means-tested transfers and Federal tax policy. In 1983, this had declined to 5.7 percent. Beginning in 1984, the downward trend reversed itself and the percentage increased to 6.6 percent in 1986.

Tables 8, 9, and 10 display the effectiveness of social insurance and means-tested programs in eliminating poverty among individuals in families with children. Table 8 presents information on individuals in all families with children under 18 years old; table 9 presents information on individuals in families that are headed by an unmarried individual and have children under 18 years old; and table 10 presents information on individuals in married-couple families with children under 18 years old. Table 9 shows that in 1979 approximately 30 percent of individuals in single-parent families were removed from poverty as the result of means-tested transfers, food and housing benefits, and Federal tax policy. By 1986, this had declined to 14 percent. Similarly, the percentage reduction in the poverty gap due to means-tested transfers and Federal tax policy fell from 56 percent to 51 percent.

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[6] See Bureau of the Census, "Alternative Methods for Valuing Selected In-Kind Transfer Benefits and Measuring Their Effect on Poverty," Technical Paper 50, March 1982, for a discussion of the estimation methods. Technical papers 51, 52, 55, and 56 provide data for all years from 1979 through 1985.

Table 11 displays the effectiveness of social insurance and means-tested transfer programs in eliminating poverty among the elderly over the 1979–1986 period. The table shows that over this period the antipoverty effectiveness of both social insurance and means-tested programs improved for the elderly: despite a significant increase in the overall elderly population, the number of individuals in poverty actually declined, and the poverty gap remained fairly level. The numbers of individuals removed from poverty by social insurance programs increased from 7.1 to 8.4 million between 1979 and 1986. The percentage of elderly individuals removed from poverty due to social insurance programs increased from 68.3 percent to 72.5 percent from 1979 to 1986. The number removed from poverty by means-tested transfer programs increased from 716,000 to 740,000 over the same period.

TABLE 7.—ANTIPOVERTY EFFECTIVENESS OF CASH AND NONCASH TRANSFERS (INCLUDING FEDERAL INCOME AND PAYROLL TAXES) FOR ALL INDIVIDUALS IN FAMILIES OR LIVING ALONE, 1979–86

	1979	1980	1981	1982	1983	1984	1985	1986
Number of poor individuals (thousands):								
Cash income before transfers	41,695	46,273	49,184	51,942	52,700	50,943	50,462	49,702
Plus social insurance (other than Social Security)	39,835	44,016	46,974	48,989	49,468	48,690	48,208	47,466
Plus Social Security	27,846	31,638	33,909	36,204	36,928	35,702	35,171	34,534
Plus means-tested cash transfers (official definition)	25,201	29,114	31,567	34,200	35,030	33,700	33,064	32,370
Plus food and housing benefits	20,931	24,882	27,703	30,493	31,697	30,103	29,489	28,988
Less Federal taxes	21,606	26,030	29,983	32,549	33,923	32,529	31,840	31,249
Number of individuals removed from poverty due to (thousands):								
Social insurance (other than Social Security)	1,860	2,257	2,210	2,953	3,232	2,253	2,254	2,236
Social insurance (including Social Security)	13,849	14,635	15,275	15,738	15,772	15,241	15,291	15,168
Means-tested cash, food, and housing benefits	6,915	6,756	6,206	5,711	5,231	5,599	5,682	5,546
Federal taxes	−675	−1,148	−2,280	−2,056	−2,226	−2,426	−2,351	−2,261
Percent of individuals removed from poverty due to:								
Social insurance (including Social Security)	33.2	31.6	31.1	30.3	29.9	29.9	30.3	30.5
Means-tested cash, food and housing benefits and Federal taxes	15.0	12.1	8.0	7.0	5.7	6.2	6.6	6.6
Poverty gap (millions of 1985 dollars):								
Cash income before transfers	94,970	105,707	111,979	117,024	120,015	116,034	115,854	116,402
Plus social insurance (other than Social Security)	88,535	97,951	104,626	108,668	110,446	108,857	109,319	110,145
Plus Social Security	49,136	55,308	60,389	64,856	67,651	65,393	64,667	65,044
Plus means-tested cash transfers (official definition)	34,077	39,224	44,307	48,573	50,414	47,990	47,809	48,289
Plus food and housing benefits	26,685	30,533	35,460	38,534	40,165	37,903	37,816	38,183
Less Federal taxes	27,113	31,202	36,684	39,890	41,660	39,538	39,400	39,728

Percentage reduction in poverty gap due to:								
Social insurance (including Social Security)	48.3	47.7	46.1	44.6	43.6	43.6	44.2	44.1
Means-tested cash, food and housing benefits and Federal taxes	23.2	22.8	22.8	21.3	21.7	22.3	21.8	21.7
Poverty rate (in percent):								
Cash income before transfers	19.1	20.6	21.7	22.6	22.8	21.8	21.3	20.8
Plus social insurance (other than Social Security)	18.3	19.6	20.7	21.4	21.4	20.8	20.4	19.9
Plus Social Security	12.8	14.1	14.9	15.8	15.9	15.3	14.9	14.5
Plus means-test cash transfers (official definition)	11.6	12.9	13.9	14.9	15.1	14.4	14.0	13.6
Plus food and housing benefits	9.6	11.1	12.2	13.3	13.7	12.9	12.5	12.2
Less Federal taxes	9.9	11.6	13.2	14.2	14.6	13.9	13.5	13.1

Source: Congressional Budget Office and committee staff.

TABLE 8.—ANTIPOVERTY EFFECTIVENESS OF CASH AND NONCASH TRANSFERS (INCLUDING FEDERAL INCOME AND PAYROLL TAXES) FOR ALL INDIVIDUALS IN FAMILIES WITH RELATED CHILDREN LESS THAN 18, 1979–86

	1979	1980	1981	1982	1983	1984	1985	1986
Number of poor individuals (thousands):								
Cash income before transfers	21,510	24,795	26,446	28,759	28,935	27,277	26,639	26,121
Plus social insurance (other than Social Security)	20,559	23,518	25,204	26,895	26,948	26,010	25,368	24,824
Plus Social Security	18,599	21,544	23,111	25,036	25,255	24,408	23,701	23,292
Plus means-tested cash transfers (official definition)	16,808	19,902	21,553	23,796	24,246	23,301	22,547	22,111
Plus food and housing benefits	13,261	16,463	18,465	20,903	21,736	20,616	19,847	19,572
Less Federal taxes	13,638	17,370	20,159	22,503	23,420	22,405	21,586	21,199
Number of individuals removed from poverty due to (thousands):								
Social insurance (other than Social Security)	951	1,277	1,242	1,864	1,987	1,267	1,271	1,297
Social insurance (including Social Security)	2,911	3,251	3,335	3,723	3,680	2,869	2,938	2,829
Means-tested cash, food, and housing benefits	5,338	5,081	4,646	4,133	3,519	3,792	3,854	3,720
Federal taxes	−377	−807	−1,694	−1,600	−1,684	−1,789	−1,739	−1,627
Percent of individuals removed from poverty due to:								
Social insurance (including Social Security)	13.5	13.1	12.6	12.9	12.7	10.5	11.0	10.8
Means-tested cash, food and housing benefits and Federal taxes	23.1	17.2	11.2	8.8	6.3	7.3	7.9	8.0
Poverty gap (millions of 1985 dollars):								
Cash income before transfers	35,967	41,785	44,249	48,743	49,992	46,989	45,989	45,907
Plus social insurance (other than Social Security)	33,907	38,723	41,299	45,085	45,791	44,234	43,651	43,564
Plus Social Security	28,891	33,570	35,857	39,995	40,871	39,532	38,699	38,836
Plus means-tested cash transfers (official definition)	18,572	22,299	24,732	28,540	28,992	27,787	27,118	27,095
Plus food and housing benefits	12,509	15,105	17,554	20,169	20,460	19,476	18,822	18,735
Less Federal taxes	12,503	15,239	18,059	20,791	21,170	20,265	19,520	19,388

Percentage reduction in poverty gap due to:								
Social insurance (including Social Security)	19.7	19.7	19.0	17.9	18.2	15.9	15.9	15.4
Means-tested cash, food and housing benefits and Federal taxes	45.6	43.9	40.2	39.4	39.4	41.0	41.7	42.4
Poverty rate (in percent):								
Cash income before transfers	16.5	18.6	20.0	21.7	21.9	20.7	20.0	19.5
Plus social insurance (other than Social Security)	15.8	17.6	19.0	20.3	20.4	19.7	19.0	18.5
Plus Social Security	14.3	16.1	17.4	18.9	19.2	18.5	17.8	17.4
Plus means-tested cash transfers (official definition)	12.9	14.9	16.3	17.9	18.4	17.6	16.9	16.5
Plus food and housing benefits	10.2	12.3	13.9	15.7	16.5	15.6	14.9	14.6
Less Federal taxes	10.5	12.9	15.2	17.0	17.8	17.0	16.2	15.8

Source: Congressional Budget Office and Committee staff.

TABLE 9.—ANTIPOVERTY EFFECTIVENESS OF CASH AND NONCASH TRANSFERS (INCLUDING FEDERAL INCOME AND PAYROLL TAXES) FOR INDIVIDUALS IN ALL UNITS WITH AN UNMARRIED HEAD AND RELATED CHILDREN LESS THAN 18, 1979–1986

	1979	1980	1981	1982	1983	1984	1985	1986
Number of poor individuals (thousands):								
Cash income before transfers	11,480	12,458	12,915	13,594	13,751	13,774	13,685	14,069
Plus social insurance (other than Social Security)	11,271	12,207	12,689	13,284	13,501	13,513	13,391	13,790
Plus Social Security	10,367	11,201	11,858	12,579	12,611	12,786	12,581	13,143
Plus means-tested cash transfers (official definition)	9,230	10,362	10,987	11,903	12,063	12,132	11,943	12,487
Plus food and housing benefits	6,901	8,363	9,191	10,312	10,531	10,473	10,418	10,879
Less Federal taxes	6,925	8,433	9,423	10,611	10,800	10,695	10,670	11,217
Number of individuals removed from poverty due to (thousands):								
Social insurance (other than Social Security)	209	251	226	310	250	261	294	279
Social insurance (including Social Security)	1,113	1,257	1,057	1,015	1,140	988	1,104	926
Means-tested cash, food and housing benefits	3,466	2,838	2,667	2,267	2,080	2,313	2,163	2,264
Federal taxes	−24	−70	−232	−299	−269	−222	−252	−338
Percent of individuals removed from poverty due to:								
Social insurance (including Social Security)	9.7	10.1	8.2	7.5	8.3	7.2	8.1	6.6
Means-tested cash, food and housing benefits and Federal taxes	30.0	22.2	18.9	14.5	13.2	15.2	14.0	13.7
Poverty gap (millions of 1985 dollars):								
Cash income before transfers	23,138	25,568	26,850	28,841	29,851	29,057	29,096	30,252
Plus social insurance (other than Social Security)	22,486	24,672	26,092	27,904	28,752	28,116	28,244	29,564
Plus Social Security	19,843	21,792	23,352	25,190	25,913	25,615	25,372	27,009
Plus means-tested cash transfers (official definition)	11,378	13,056	14,631	16,393	17,025	16,650	16,633	17,819
Plus food and housing benefits	7,052	7,961	9,433	10,487	11,064	10,741	10,589	11,478
Less Federal taxes	7,001	7,940	9,478	10,567	11,134	10,835	10,667	11,574

Percentage reduction in poverty gap due to:								
Social insurance (including Social Security)	14.2	14.8	13.0	12.7	13.2	11.8	12.8	10.7
Means-tested cash, food and housing benefits and Federal taxes	55.5	54.2	51.7	50.7	49.5	50.9	50.5	51.0
Poverty rate (in percent):								
Cash income before transfers	50.0	51.6	52.1	54.5	53.8	51.5	50.7	51.4
Plus social insurance (other than Social Security)	49.1	50.6	51.2	53.2	52.8	50.5	49.6	50.3
Plus Social Security	45.1	46.4	47.8	50.4	49.3	47.8	46.6	48.0
Plus means-tested cash transfers (official definition)	40.2	43.0	44.3	47.7	47.2	45.3	44.3	45.6
Plus food and housing benefits	30.0	34.7	37.1	41.3	41.2	39.1	38.6	39.7
Less Federal taxes	30.1	35.0	38.0	42.5	42.2	40.0	39.6	40.9

Source: Congressional Budget Office and Committee staff.

TABLE 10.—ANTIPOVERTY EFFECTIVENESS OF CASH AND NONCASH TRANSFERS (INCLUDING FEDERAL INCOME AND PAYROLL TAXES) FOR ALL INDIVIDUALS IN MARRIED-COUPLE FAMILIES WITH RELATED CHILDREN LESS THAN 18, 1979–86

	1979	1980	1981	1982	1983	1984	1985	1986
Number of poor individuals (thousands):								
Cash income before transfers	10,030	12,337	13,531	15,165	15,184	13,503	12,954	12,052
Plus social insurance (other than Social Security)	9,288	11,311	12,515	13,611	13,447	12,497	11,977	11,034
Plus Social Security	8,232	10,343	11,253	12,457	12,644	11,622	11,120	10,149
Plus means-tested cash transfers (official definition)	7,578	9,540	10,566	11,893	12,183	11,169	10,604	9,624
Plus food and housing benefits	6,360	8,100	9,274	10,591	11,205	10,143	9,429	8,693
Less Federal taxes	6,713	8,937	10,736	11,892	12,620	11,710	10,916	9,982
Number of individuals removed from poverty due to (thousands):								
Social insurance (other than Social Security)	742	1,026	1,016	1,554	1,737	1,006	977	1,018
Social insurance (including Social Security)	1,798	1,994	2,278	2,708	2,540	1,881	1,834	1,903
Means-tested cash, food and housing benefits	1,872	2,243	1,979	1,866	1,439	1,479	1,691	1,456
Federal taxes	−353	−837	−1,462	−1,301	−1,415	−1,567	−1,487	−1,289
Percent of individuals removed from poverty due to:								
Social insurance (including Social Security)	17.9	16.2	16.8	17.9	16.7	13.9	14.2	15.8
Means-tested cash, food and housing benefits and Federal taxes	15.1	11.4	3.8	3.7	0.2	−0.7	1.6	1.4
Poverty gap (millions of 1985 dollars):								
Cash income before transfers	12,829	16,217	17,399	19,902	20,141	17,932	16,893	15,655
Plus social insurance (other than Social Security)	11,421	14,051	15,207	17,181	17,039	16,118	15,407	14,000
Plus Social Security	9,048	11,778	12,505	14,805	14,958	13,917	13,327	11,827
Plus means-tested cash transfers (official definition)	7,194	9,243	10,101	12,147	11,967	11,137	10,485	9,276

Plus food and housing benefits	5,457	7,144	8,121	9,682	9,396	8,735	8,233	7,257
Less Federal taxes	5,502	7,299	8,581	10,224	10,036	9,430	8,853	7,814
Percentage reduction in poverty gap due to:								
Social insurance (including Social Security)	29.5	27.4	28.1	25.6	25.7	22.4	21.1	24.5
Means-tested cash, food and housing benefits and Federal taxes	27.6	27.6	22.6	23.0	24.4	25.0	26.5	25.6
Poverty rate (in percent):								
Cash income before transfers	9.4	11.2	12.6	14.1	14.3	12.8	12.2	11.3
Plus social insurance (other than Social Security)	8.7	10.3	11.6	12.6	12.7	11.9	11.3	10.4
Plus Social Security	7.7	9.4	10.4	11.6	11.9	11.0	10.5	9.5
Plus means-tested cash transfers (official definition)	7.1	8.7	9.8	11.0	11.5	10.6	10.0	9.0
Plus food and housing benefits	5.9	7.4	8.6	9.8	10.5	9.6	8.9	8.2
Less Federal taxes	6.3	8.1	10.0	11.0	11.9	11.1	10.3	9.4

Source: Congressional Budget Office and Committee staff.

TABLE 11.—ANTIPOVERTY EFFECTIVENESS OF CASH AND NONCASH TRANSFERS (INCLUDING FEDERAL INCOME AND PAYROLL TAXES) FOR INDIVIDUALS IN UNITS WITH ALL MEMBERS 65 OR OLDER, 1979–86

	1979	1980	1981	1982	1983	1984	1985	1986
Number of poor individuals (thousands):								
Cash income before transfers	10,385	10,821	10,884	10,772	10,843	11,009	11,200	11,550
Plus social insurance (other than Social Security)	10,165	10,650	10,763	10,604	10,654	10,862	11,033	11,334
Plus Social Security	3,288	3,441	3,353	3,226	3,231	3,072	3,146	3,176
Plus means-tested cash transfers (official definition)	2,936	3,133	3,066	3,005	2,928	2,717	2,831	2,874
Plus food and housing benefits	2,572	2,708	2,621	2,631	2,520	2,250	2,347	2,436
Less Federal taxes	2,577	2,717	2,644	2,638	2,533	2,256	2,353	2,446
Number of individuals removed from poverty due to (thousands):								
Social insurance (including Social Security)	7,097	7,380	7,531	7,546	7,612	7,937	8,054	8,374
Means-tested cash, food and housing benefits	716	733	732	595	711	822	799	740
Federal taxes	−5	−9	−23	−7	−13	−6	−6	−10
Percent of individuals removed from poverty due to (thousands):								
Social insurance (including Social Security)	68.3	68.2	69.2	70.1	70.2	72.1	71.9	72.5
Means-tested cash, food and housing benefits and Federal taxes	6.8	6.7	6.5	5.5	6.4	7.4	7.1	6.3
Poverty gap (millions of 1985 dollars):								
Cash income before transfers	32,433	34,810	35,026	34,695	34,502	34,918	35,796	37,073
Plus social insurance (other than Social Security)	30,908	33,322	33,859	33,648	33,261	33,721	34,619	35,898
Plus Social Security	5,544	5,554	5,404	5,542	5,382	4,955	5,217	5,314
Plus means-tested cash transfers (official definition)	3,695	3,709	3,787	3,943	3,531	3,131	3,535	3,755
Plus food and housing benefits	3,191	3,153	3,210	3,442	3,070	2,623	2,984	3,206
Less Federal taxes	3,200	3,165	3,218	3,450	3,082	2,630	2,991	3,215
Percentage reduction in poverty gap due to:								
Social insurance (including Social Security)	82.9	84.0	84.6	84.0	84.4	85.8	85.4	85.7
Means-tested cash, food and housing benefits and Federal taxes	7.2	6.9	6.2	6.0	6.7	6.7	6.2	5.7
Poverty rate for individuals (in percent):								
Cash income before transfers	60.0	60.1	58.9	57.3	56.2	56.3	56.6	55.8

Plus social insurance (other than Social Security)	58.7	59.1	58.2	56.4	55.3	55.5	55.7	54.7
Plus Social Security	19.0	19.1	18.1	17.2	16.8	15.7	15.9	15.3
Plus means-tested cash transfers (official definition)	17.0	17.4	16.6	16.0	15.2	13.9	14.3	13.9
Plus food and housing benefits	14.9	15.0	14.2	14.0	13.1	11.5	11.8	11.8
Less Federal taxes	14.9	15.1	14.3	14.0	13.1	11.5	11.9	11.8

Source: Congressional Budget Office and Committee staff.

Table 12 shows the effects of child support and alimony payments in reducing poverty. In 1985, receipt of income from these sources reduced the number of poor families by about 5 percent, and lowered the poverty gap by $3.2 billion, a drop of nearly 7 percent. The largest effect was on single-parent families with children; their poverty rate was reduced by 6 percent and their poverty gap declined by 8 percent.

TABLE 12.—NUMBER OF FAMILIES AND REDUCTION IN POVERTY GAP DUE TO RECEIPT OF CHILD SUPPORT AND/OR ALIMONY PAYMENTS, 1985

	All families	All families with children	Single parents with children	Other families with childern
Reduction in:				
Number of poor families (thousands)	415	284	206	78
Poverty gap (billions)	$3.2	$2.6	$2.0	$0.6
Poverty rate	0.6	0.9	2.8	0.3
Percentage reduction in:				
Number of poor families	4.9	4.8	5.8	3.4
Poverty gap	6.6	6.8	7.9	4.6

Note.—The number 415 under the heading "All families," means that 415,000 families were removed from poverty as a result of receiving child support and/or alimony.

Source: Congressional Budget Office tabulations of the March 1986 Current Population Survey.

EXPLANATIONS FOR INCREASES IN POVERTY BETWEEN 1979 AND 1986

As noted in table 7 of the previous subsection, between 1979 and 1986 the number of poor persons (using a modified definition of poverty which includes market and social insurance income, means-tested transfers and Federal taxes) increased from 21.6 to 31.2 million, representing a net increase in the poverty population of 45 percent, and an increase in the poverty rate from 9.9 percent to 13.1 percent. The aggregate "poverty gap," which is the difference between a poor family's disposable income and the poverty level, summed across all poor families, grew from $27.1 billion to $39.7 billion, representing an increase of $12.6 billion.

Several factors have potentially contributed to these changes in the level of poverty and the poverty gap, including demographic changes (size and composition of the population), changes in wages and other private sources of income (market income) relative to inflation, and changes in the effectiveness of Federal social programs and tax policy. The goal of this analysis is to determine how significant a contribution each of these factors has made to the increase in the number of poor persons and the poverty gap noted above. Because individuals in different family types have been differentially affected by each of these factors, this analysis seeks to highlight trends for individuals in various family types.

METHODOLOGY

A family is officially classified as poor if cash income (wages, pensions, Social Security benefits, AFDC benefits and all other forms of cash income) is less than the poverty threshold. The poverty threshold in 1986 was $11,203 for a family of four persons. For the purpose of this analysis, this official definition of poverty was modified by adding near-cash benefits (such as the value of food and housing benefits) to income, and subtracting Federal income and payroll taxes from income. If this "disposable income" was less than the poverty threshold, all the individuals in the family were classified as poor. With the exception of changes in Government health programs such as Medicare and Medicaid, this "disposable income" poverty measure is sensitive to all policy changes in the major social insurance and means-tested programs. To highlight the difference between this modified definition of poverty and the official definition of poverty, note that under the official definition of poverty the number of persons classified as poor increased 28 percent between 1979 and 1986, from 25.2 million to 32.4 million. The official poverty rate increased from 11.7 to 13.6 percent.

This analysis is based on the data in the previous subsection for 1979 and 1986 which describe the antipoverty effectiveness of various cash and noncash sources of income. To determine what factors have contributed to changes in the poverty of individuals in each family type, this analysis compares the effectiveness of each factor in removing individuals from poverty in 1979 with its effectiveness in 1986. A similar analysis is repeated to evaluate which factors have contributed most to the increase in the poverty gap. Note that these findings are only suggestive of general trends over this specified time period.

As an example, the numbers for individuals in families headed by an unmarried person were calculated based on the following set of data taken from table 9 of this section.

	1979 actual	1979: marginal percent left in poverty	1986 actual
Total population	22,978,000		27,392,000
Number poor, market income only	11,480,000	50.0	14,069,000
Number poor, market and social insurance income	10,367,000	90.3	13,143,000
Number poor, market and social insurance income and means-tested transfers (including food and housing)	6,901,000	66.6	10,879,000
Number poor, all cash income and means-tested transfers, after Federal taxes (payroll and income)	6,925,000	100.3	11,217,000

These data show that if one takes into account market income only, 50.0 percent of individuals in this family type would have been classified as poor in 1979. If market income had been as successful in taking people out of poverty in 1986 as in 1979, 13,685,000 (approximately 50.0%×27,392,000) individuals would have been poor counting only market income. However, 14,069,000 individuals were actually poor in 1986, implying an increase in the poverty population due to market income of 384,000.

In 1979, social insurance income left in poverty 90.3 percent of those in poverty counting only market income. To determine the marginal effect of social insurance income on the increased number of poor between 1979 and 1986, one applies this percentage to the number actually poor in 1986 after market income. If social insurance income had been as successful in taking people out of poverty in 1986 as in 1979, 12,705,000 (90.3%×14,069,000) individuals would have been poor counting both market and social insurance income. However, 13,143,000 individuals were actually poor in 1986, implying an increase in the poverty population due to social insurance income of 438,000. This methodology was repeated to gauge the impact of both means-tested transfers and Federal taxes on the increased number in poverty.

Because the population grew 9.5 percent over the 1979 to 1986 period, the effect of "average" population growth was computed. Counting all sources of income (market and social insurance income, means-tested transfers, and Federal taxes), 30.1 percent of the population was left in poverty in 1979. Assuming these sources of income had the same effect on the number poor in 1986 as in 1979, but population grew 9.5 percent, we would expect an increase in the poverty population of 658,000 (22,978,000×.095×30.1%).

Finally, the increase in the number poor that could not be attributed to the changed effectiveness of the various income sources or to average population growth was attributed to an "other" category. Among other things, this category would take into account above- or below-average population growth.

This procedure was followed to attribute increases in poverty for each family type, and to attribute increases in the poverty gap for each family type.

EXPLANATIONS FOR THE INCREASE IN THE POVERTY POPULATION

Table 13 presents data which suggest the factors contributing to the increase in the number of poor persons between 1979 and 1986, broken down by type of family. The last column of the table illustrates the overall contribution of each factor. Based on this methodology, changes in means-tested programs added over 3 million people to the poverty population, changes in market income added 1.9 million, changes in Federal tax policy added 1.3 million, and changes in social insurance programs added roughly 1 million. Population growth and all other changes added an additional 2.4 million. In percentage terms, the largest contributing factor was the reduced effectiveness of means-tested welfare programs (31 percent), followed by population growth (21 percent), changes in market income (20 percent), the reduced effectiveness of Federal tax policy (14 percent), and the reduced effectiveness of social insurance programs (10 percent).

Individuals in families with children headed by an unmarried person accounted for 44 percent of the total increase in the number of poor persons, although they comprise but 11 percent of the population. Means-tested welfare programs tend to be targeted toward this group, and they rely more heavily on these programs to escape poverty than other individuals. The reduced effectiveness of means-tested welfare programs accounted for 50 percent of the increase in poverty among this group. Population growth and other residual changes accounted for another 24 percent. Other factors (changes in the effectiveness of market income, social insurance programs, and Federal taxes) each accounted for roughly 10 percent.

Individuals in families with children headed by a married couple accounted for 34 percent of the total increase in the number of poor persons, although they comprise 49 percent of the population. These individuals are often not eligible for means-tested programs and tend to rely more heavily on earnings to escape poverty. Declining market incomes relative to inflation were a major contributing factor to their increase in poverty (64 percent), followed by the reduced effectiveness of means-tested programs (26 percent), and the reduced effectiveness of Federal tax policy (25 percent). Population growth and "other" factors (primarily demographic changes) reduced the number in poverty in this group by 755,000, representing an offsetting contribution of 23 percent to the total increase in poverty.

Individuals in households with all members over 65, who comprise 8 percent of the total population, experienced a very small net decline in the size of their poverty population. This occurred even though population growth among individuals in this group was much higher than average, adding over 1 million individuals to the poverty population. The net decline in the number poor was so small that it makes little sense to look at the percentage contribution of each of the factors. What is most surprising is that market income, which includes private pensions, reduced the official pretransfer poverty rate over this 7-year period (although not shown in the table, the official poverty rate fell by 4 percentage points). With the exception of the 6-month COLA delay, no significant Social Security policy changes occurred for this group. Real Social Security benefits and SSI benefits increased; consequently, both social insurance and welfare programs were more effective in removing individuals in this group from poverty in 1986 than they were in 1979.

Individuals in "other" family types include nonelderly individuals and married couples without children, and other family groups without children that are not 100 percent elderly. Individuals in this group accounted for 23 percent of the increase in the poverty population, although they comprise 32 percent of the total population. The reduced effectiveness of social insurance programs accounted for 34 percent of the increase in the number poor, as UI benefits decreased in real terms and eligibility for UI and student benefits was tightened (in particular, eligibility standards for part-year and/or part-time individuals were raised by the States). This group was also affected by tightened disability insurance eligibility. As individuals in this group tend not to be eligible for most types of means-tested welfare benefits, changes in welfare programs contributed little to increases in this group's poverty population. Changes in market income and Federal tax policy together accounted for 24 percent of the increase. Population growth and other residual changes accounted for 39 percent of the increase in the number poor in this family type.

EXPLANATIONS FOR THE INCREASE IN THE POVERTY GAP

The poverty gap is an important complementary approach to evaluating poverty. Over time changes in income and the effectiveness of Federal programs and policies may do little to reduce the number who are counted as poor, but may have a very real impact in reducing the degree of poverty. This is especially relevant when one considers that eligibility was tightened in some Federal programs, such as UI and Social Security, while benefits were reduced in others, such as AFDC and food stamps. Eligibility tightening in programs tends to make a greater percentage contribution to increases in the poverty gap than to increases in the poverty population.

Table 14 presents data which suggest the factors contributing to the increase in the poverty gap between 1979 and 1986, broken down by type of family. The last column of the table illustrates the overall contribution of each factor. Population growth, changes in market incomes and other residual changes accounted for 45 percent of the increase in the aggregate poverty gap, followed by social insurance programs (26 percent), means-tested program changes (22 percent), and changes in Federal tax policy (7 percent).

Individuals in families with children headed by an unmarried person accounted for 36 percent of the increase in the aggregate poverty gap. The reduced effectiveness of means-tested transfer programs accounted for 41 percent of this increase, followed by population growth, changes in market income and other residual changes (32 percent), social insurance programs (23 percent), and Federal tax policy changes (4 percent). Changes in means-tested programs and tax policies together reduced the aggregate income of this group by $2.1 billion out of a total $4.6 billion loss.

Individuals in married-couple families with children accounted for 18 percent of the increase in the aggregate poverty gap. Reduced effectiveness of means-tested welfare programs contributed little to the total implied income loss of $2.3 billion. Changes in earnings, tax policy and social insurance programs were most significant.

Individuals in "other" family types accounted for 45 percent of the increase in the aggregate poverty gap. This is primarily due to this group's tendency to rely more on social insurance programs, and the tighter eligibility requirements in these programs over this period. Social insurance programs accounted for 42 percent of the total income loss among this group of $5.7 billion.

IMPACT ON THE SIZE OF THE POVERTY POPULATION AND THE POVERTY GAP IF TAX REFORM HAD BEEN IN EFFECT IN 1986

Table 15 presents data from CBO which describe the net number of persons taken out of poverty and the net reduction in the poverty gap in 1986 if policies enacted in the 1986 tax reform law had been in effect. Overall, it is estimated that the tax reform policies would have removed over 1 million people from poverty, and would have reduced the aggregate poverty gap by almost $800 million.

TABLE 13.—SOURCES OF THE INCREASE IN THE POVERTY POPULATION BETWEEN 1979 AND 1986, BY TYPE OF FAMILY

[Thousands of persons]

	Type of family					Total
	All families with children under 18			All members over age 65	Other	
	Unmarried head	Married couple	Total			
Increased number of after-transfer poor (1979–1986) due to:						
Average population growth	658	638	1,296	245	512	2,054
Market income changes	384	2,108	2,492	−878	300	1,914
Social insurance program changes	438	257	695	−481	750	965
Means-tested program changes	2,130	852	2,982	−48	79	3,013
Federal tax changes	300	807	1,107	5	223	1,335
Other (primarily demographic)	382	−1,393	−1,011	1,026	347	362
Total increase	4,292	3,269	7,561	−131	2,213	9,643
Percent of total increase	44	34	78	−1	23	100
Percent of total population	11	49	60	8	32	100
Percentage contribution, by source:						
Average population growth	15	20	17	NA	23	21
Market income changes	9	64	33	NA	14	20
Social insurance program changes	10	8	9	NA	34	10
Means-tested program changes	50	26	39	NA	4	31
Federal tax changes	7	25	15	NA	10	14
Other (primarily demographic)	9	−43	−13	NA	16	4
Total	100	100	100	NA	100	100

TABLE 14.—SOURCES OF THE INCREASE IN THE POVERTY GAP BETWEEN 1979 AND 1986, BY TYPE OF FAMILY

[Constant 1985 dollars, in millions]

	Type of family					Total
	All families with children under 18			All members over age 65	Other	
	Unmarried head	Married couple	Total			
Increase in poverty gap (1979–1986) due to:						
Market incomes/demographic/other	1,450	905	2,355	891	2,429	5,675
Social insurance program changes	1,065	786	1,851	−1,023	2,402	3,230
Means-tested program changes	1,879	124	2,003	147	629	2,780
Federal tax changes	179	497	676	−0	255	931
Total increase	4,573	2,312	6,885	15	5,715	12,615
Percent of total increase	36	18	54	NA	45	100
Percentage contribution, by source:						
Market incomes/demographic/other	32	39	34	NA	43	45
Social insurance program changes	23	34	27	NA	42	26
Means-tested program changes	41	5	29	NA	11	22
Federal tax changes	4	22	10	NA	4	7
Total increase	100	100	100	NA	100	100

TABLE 15.—REDUCTION IN POVERTY POPULATION AND THE POVERTY GAP ASSUMING TAX REFORM IN EFFECT IN 1986, BY TYPE OF FAMILY

	Type of family					Total
	All families with children under 18			All members over age 65	Other	
	Unmarried head	Married couple	Total			
Poverty Population (thousands)						
Number added to poverty between 1979 and 1986 due to Federal tax changes	300	807	1,107	5	223	1,335
Number added to poverty between 1979 and 1986 due to Federal tax changes, assuming tax reform in effect in 1986	−13	−33	−46	5	234	193
Reduction in poverty population as a result of tax reform	313	840	1,153	0	−11	1,142
Poverty Gap (millions)						
Increase in poverty gap between 1979 and 1986 due to Federal tax changes	179	497	676	0	255	931
Increase in poverty gap between 1979 and 1986 due to Federal tax changes, assuming tax reform in effect in 1986	−29	−77	−106	0	239	133
Reduction in poverty gap as a result of tax reform	208	574	782	0	16	798

TRENDS IN FAMILY INCOME AND INCOME INEQUALITY, 1970–1986 [7] [8]

MEASURING FAMILY INCOME

Family income trends are commonly tracked by looking at real median family cash income over time, but this approach has significant shortcomings. First, because of changes in family size and composition, median family income is an inaccurate indicator of well-being. Income adjustments that account for the varying needs of different size households yield a better measure. Second, using the Consumer Price Index (CPI) to correct for inflation overstated the increase in living costs until the index was altered in 1983. Alternative indices would better reflect cost changes. Third, only cash income is generally included in measures of well-being; income received in kind, such as health insurance or food stamps, has been ignored. Yet noncash benefits have comprised a growing share of total income over the last two decades, and their omission overstates losses or understates gains in family income. Finally, although after-tax income more accurately measures a family's purchasing power, pre-tax income is generally used as the relevant indicator. Because income and payroll taxes rose as a share of income through the 1970's before dipping slightly in more recent years, using pre-tax income misstates changes in family well-being.

The income data presented here are based on pre-tax cash incomes reported on the Current Population Survey (CPS), adjusted for family size and inflation. Income is measured as a percentage of poverty thresholds to account for variations in resources needed for families of different sizes to achieve the same standard of living. An alternative price index, the CPI–X1, is used to correct for inflation; it provides a better indicator of changing living costs than does the CPI. Unfortunately, because of data limitations, in-kind income is not included and taxes are not excluded.

TRENDS IN FAMILY INCOME

As table 16 demonstrates, the median income (measured as a percentage of poverty thresholds) of all family units rose from about two and one-half times poverty in 1970 to more than three times poverty in 1986, an increase of 20 percent. Further, over this 1970–1986 period, median family incomes increased for each major family type. These aggregate income data, however, fail to describe the wide variations in both income levels and growth rates across family types during this period.

In 1970, the median incomes of elderly unrelated individuals and single mothers with children were just above the poverty line, compared with over four times the proverty threshold for nonelderly childless families. Incomes of other family types clustered around two and one-half times poverty. By 1986, differential income growth had broadened the range: the median income of single mothers was still only slightly above poverty, while that of elderly unrelated individuals had climbed about 50 percent to more than one and one-half times the poverty level, and that of nonelderly childless families had increased about 20 percent to nearly five times poverty.

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[7] This subsection is from "Trends in Family Income: 1970–1986," Congressional Budget Office, February 1988.

[8] Trends in income and income inequality reflect in part changes in the sources of income upon which different family types rely. Please see Appendix G for information on income sources upon which individuals in families with children rely (including families headed by an unmarried person), and Appendix H for information on income sources upon which individuals in elderly households rely.

For the elderly, whose income grew fastest, the upward trend was fairly steady throughout the 16-year period. Other groups were more subject to economic tides that caused incomes to fall in recessions in the mid-1970's and the early 1980's, and rise during intervening upswings including the current recovery that began in 1983.

TRENDS IN INCOME INEQUALITY AMONG FAMILY TYPES

By classifying each family into one of five quintiles,[9] one can perceive trends in the frequency by which particular family types appear in the various quintiles. As tables 17 and 18 show, the uneven growth of family incomes over the 1970-1986 period, both within and across family types, casued some significant changes in these frequencies.

Most notably, between 1970 and 1986, the fraction of elderly unrelated individuals in the bottom quintile of the income distribution for all families dropped dramatically from 60 to 41 percent, and that for elderly childless families was halved from 22 to 10 percent. The share of elderly families below the overall median also declined somewhat, from 60 to 48 percent for childless families and from 86 to 78 percent for unrelated individuals.

The only other major change in the distribution of families across overall income quintiles was in the fraction of all families with children in the lowest income category, which increased from 16 percent in 1970 to 22 percent in 1986. Note that this increase was primarily due to the increased percentage of such families headed by single mothers, since data show that neither married couples nor single mothers experienced much change in their likelihood of being in the lowest quintile.

TRENDS IN INCOME DISTRIBUTION WITHIN FAMILY TYPES

Income growth between 1970 and 1986 also varied widely across income levels, leading to greater income inequality for all family types as a group, for families with children, and for nonelderly childless families, while reducing the inequality of incomes for other family types.

Table 19 shows that for all families and unrelated individuals considered as a single group, the incomes defining each quintile grew at roughly the same pace from 1970 through 1978. After that time, however, growth rates diverged sharply, with those at the top of the income distribution experiencing greater income gains than those at the bottom. Over the entire 16-year period, the 80th percentile income rose 29 percent, compared with only a 9-percent gain for the 20th percentile income, causing a widening of the gap between high- and low-income families.

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[9] Income quintiles are fifths of the income distribution, defined by ordering all relevant family units from that with the lowest income (defined as a percentage of the poverty threshold) to that with the highest. The bottom quintile is the lowest fifth of that ordering, while the top quintile is the highest fifth. Quintiles may be defined separately for each family type, in which case the quintile a particular family is in says nothing about its place in the overall income distribution for all families as a group, but does reflect changes in income inequality within a particular family type. Quintiles may also be defined for all family types as a group, to reflect overall changes in income inequality and to describe changes in income inequality among different family types.

A similar pattern of increasing income inequality occurred for all families with children. Over the entire 16-year period, the 80th percentile income increased 27 percent, compared with a 12-percent drop in the 20th percentile income. Note that these income trends for all families with children reflect both the trends of specific types of families with children (married couple versus single mother versus other), and the growing proportion of single-mother families (who tend to have lower incomes) within the group of all families with children.

The divergence of incomes was smaller but still pronounced among nonelderly childless families. Over the full 16 years, the 80th percentile income grew by 27 percent, but the 20th percentile income increased by only 12 percent, again expanding the gap between low- and high-income families.

Among other family types, there was either no change or some lessening of inequality.

TABLE 16.—MEDIAN INCOME AS A PERCENTAGE OF THE POVERTY THRESHOLD, BY FAMILY TYPE, SELECTED YEARS 1970–1986

[In percent of poverty thresholds]

Family type	1970	1975	1980	1985	1986	Percent increase, 1980–86
All families	260	274	291	303	313	8
Families with children	251	263	275	280	287	4
Married couples with children	266	287	312	323	336	8
Single mothers with children	112	114	128	119	114	−11
Nonelderly childless families	407	426	461	469	491	7
Nonelderly unrelated individuals	238	239	266	279	289	9
Elderly childless families	215	251	278	314	323	16
Elderly unrelated individuals	107	133	140	160	161	15

TABLE 17.—PERCENTAGE OF FAMILIES WITH INCOME [1] BELOW THE MEDIAN INCOME FOR ALL FAMILIES, BY FAMILY TYPE, 1970–1986

Family type	1970	1975	1980	1985	1986
Families with children	52	53	54	55	55
Married couples	47	46	45	46	45
Single mothers	87	87	85	85	86
Other families	65	55	62	59	59
Nonelderly units:					
Childless families	23	24	23	26	25
Unrelated individuals	55	56	55	54	55

TABLE 17.—PERCENTAGE OF FAMILIES WITH INCOME [1] BELOW THE MEDIAN INCOME FOR ALL FAMILIES, BY FAMILY TYPE, 1970–1986—Continued

Family type	1970	1975	1980	1985	1986
Elderly units:					
Childless families	60	55	53	48	48
Unrelated individuals	86	84	84	78	78

[1] Family income is measured as income divided by the poverty threshold for that family size.

TABLE 18.—PERCENTAGE OF FAMILIES WITH INCOME [1] BELOW THE 20TH PERCENTILE INCOME FOR ALL FAMILIES, 1970–1986

Family type	1970	1975	1980	1985	1986
Families with children	16	19	20	22	22
Married couples	10	12	12	13	12
Single mothers	54	56	53	54	56
Other families	18	18	24	24	22
Nonelderly units:					
Childless families	6	6	6	7	7
Unrelated individuals	28	28	25	24	25
Elderly units:					
Childless families	22	15	14	11	10
Unrelated individuals	59	50	48	40	41

[1] Family income is measured as income divided by the poverty threshold for that family size.

TABLE 19.—PERCENT GROWTH IN MEDIAN INCOME [1] BY FAMILY TYPE AND INCOME PERCENTILE, SELECTED PERIODS, 1970–1986

Family type/percentile	1970–1978	1978–1986	1970–1986
All families and unrelated individuals:			
20th	11	−1	9
40th	13	4	17
Median	13	6	20
60th	14	8	22
80th	15	12	29
All families with children:			
20th	3	−14	−12
40th	11	−2	9
Median	13	1	14
60th	15	3	19
80th	16	10	27
Nonelderly childless families:			
20th	15	−3	12
40th	15	3	18
Median	15	5	21
60th	15	8	24
80th	14	11	27

TABLE 19.—PERCENT GROWTH IN MEDIAN INCOME [1] BY FAMILY TYPE AND INCOME PERCENTILE, SELECTED PERIODS, 1970–1986—Continued

Family type/percentile	1970–1978	1978–1986	1970–1986
Married couples with children:			
20th	14	−2	11
40th	17	4	22
Median	19	6	26
60th	18	8	28
80th	19	13	35
Single mothers with children:			
20th	7	−18	−13
40th	5	−10	−6
Median	12	−9	2
60th	11	−4	7
80th	12	4	16
Nonelderly unrelated individuals:			
20th	21	5	27
40th	14	8	22
Median	11	9	21
60th	10	9	19
80th	10	13	24
Elderly childless families:			
20th	31	19	56
40th	26	22	53
Median	23	22	50
60th	21	22	48
80th	16	21	40
Elderly unrelated individuals			
20th	42	5	49
40th	37	8	48
Median	34	13	50
60th	33	16	54
80th	27	23	56

STATISTICS ON THE WEALTH STATUS OF HOUSEHOLDS, BY AGE OF HOUSEHOLDER [10]

The life cycle theory of saving assumes that people try to attain and at least maintain particular consumption goals over their lifetimes. The fact that most people anticipate some period of retirement, when they will no longer have current earnings from work, theoretically is a basic factor affecting savings behavior. It is common to regard the period of work as the time when savings accumlate for later retirement, and retirement as the time when assets are liquidated to provide income for current consumption.

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[10] This section borrows heavily from a CRS study, "Retirement Income for an Aging Population," prepared for the Committee on Ways and Means with analytic support from CBO, August 1987.

Tables 20, 21, and 22 present a profile of net worth and home equity by age.

TOTAL HOUSEHOLD NET WORTH

Table 20 shows percentile distributions of total household net worth [11] (wealth less unsecured debt) by age of householder. It is important to note that data on pension equity, a potentially important asset, is not available and is not included in this table. As with total income, net worth is higher among households in each successive age group, peaking among household heads between the ages of 55 and 59, and then diminishing.

Table 21 shows that household net worth tends also to be a function of income as well as age. Net worth tends to increase with income. When compared at equal income levels, net worth is greater for households with heads who are older than for households with heads who are younger.

HOME EQUITY

Table 22, which presents data on median total household net worth, median home equity, and median household net worth other than home equity, shows that the purchase of a home is the largest investment that most people make. For the majority of householders ages 35 and over, the most important component of total net worth is home equity.

TABLE 20.—TOTAL NET WORTH PERCENTILES BY AGE OF HOUSEHOLDER: 1984

Age	10th percentile	25th percentile	Median	75th percentile	90th percentile
15 to 19	–$690	0	$730	3,720	$12,594
20 to 24	–1,300	0	2,440	8,006	19,233
25 to 29	–1,095	$542	5,300	19,250	45,357
30 to 34	–167	1,700	13,665	41,470	79,756
35 to 39	0	4,850	28,320	68,124	130,173
40 to 44	650	11,364	45,825	92,000	177,598
45 to 49	520	13,500	52,341	105,344	197,225
50 to 54	600	19,618	64,475	123,105	220,835
55 to 59	1,600	25,401	72,125	139,649	250,441
60 to 64	3,020	29,000	72,588	135,756	242,850
65 to 69	1,075	25,386	65,849	126,099	223,560
70 to 74	528	18,000	59,885	112,196	197,767
75 to 79	999	18,200	58,200	114,990	190,918
80 to 84	683	15,479	52,070	102,900	162,673
85 plus	400	14,649	47,599	100,439	160,400

Source: Survey of Income and Program Participation [SIPP] Wave IV. Table prepared by the Congressional Research Service [CRS].

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[11] Net worth is defined as total household wealth less unsecured debt (credit card debt, installment debt, etc.). Household wealth includes: interest-earning assets at financial institutions, such savings accounts and certificates of deposit; other interest-earning assets, such as money-market funds and government securities; checking accounts, stocks and mutual fund shares, home equity and other real estate equity, vehicles, business or professional interests, IRA or Keogh accounts, and other financial investments. Equities in pensions, cash surrender value of life insurance policies, and the value of jewelry and home furnishings are not included.

TABLE 21.—MEDIAN TOTAL HOUSEHOLD NET WORTH BY ANNUAL INCOME AND HOUSEHOLDER'S AGE: 1984

Income bracket	All householders	Householders age 25 to 44	Householders age 45 to 64	Householders age 65 and over
Negative	$1,255	$1,942	$5,000	$32,240
$1 to $4,999	1,177	321	3,020	10,349
$5,000 to $9,999	8,050	750	19,899	28,835
$10,000 to $14,999	18,000	3,700	37,125	60,000
$15,000 to $19,999	22,650	7,450	42,450	82,375
$20,000 to $24,999	28,611	14,225	54,875	94,816
$25,000 to $29,999	32,395	18,200	63,200	128,015
$30,000 to $34,999	43,400	27,400	73,206	152,449
$35,000 to $39,999	54,983	39,728	75,714	165,249
$40,000 to $44,999	61,025	40,748	80,574	169,923
$45,000 to $49,999	67,941	51,995	84,125	170,536
$50,000 to $74,999	98,100	68,475	118,995	228,559
$75,000 to $99,999	160,548	128,341	168,258	316,700
$100,000 and over	265,275	195,827	324,871	507,100

Source: Survey of Income and Program Participation [SIPP] Wave IV. Table prepared by the Congressional Research Service [CRS].

TABLE 22.—COMPARISON OF MEDIAN HOUSEHOLD NET WORTH, HOME EQUITY, AND NET WORTH LESS HOME EQUITY: 1984

Age	Median total net worth	Median home equity	Median total net worth less home equity
15 to 19	$730	0	$600
20 to 24	2,440	0	1,820
25 to 29	5,300	0	2,828
30 to 34	13,665	$2,500	4,350
35 to 39	28,320	17,500	6,260
40 to 44	45,825	28,000	9,836
45 to 49	52,341	31,999	11,040
50 to 54	64,475	40,000	15,100
55 to 59	72,125	40,000	21,550
60 to 64	72,588	43,250	21,877
65 to 69	65,849	38,000	21,111
70 to 74	59,885	30,000	18,399
75 to 79	58,200	28,000	20,000
80 to 84	52,070	30,000	12,338
85 plus	47,599	25,000	14,790

Source: Survey of Income and Program Participation [SIPP] Wave IV. Table prepared by the Congressional Research Service [CRS].

APPENDIX J. SELECTED ECONOMIC, POPULATION, AND TAX DATA FOR THE UNITED STATES AND BY STATE

TABLE 1.—SELECTED ECONOMIC DATA

	1970	1975	1980	1985	1987
Wages:					
Average manufacturing wage [1]	$3.35	$4.83	$7.27	$9.53	[P] $9.91
Federal minimum wage	$1.60	$2.30	$3.10	$3.35	$3.35
Average annual wages and salaries [2]	$6,231	$8,504	$12,225	$15,553	[P] $16,250
In constant 1986 dollars	$17,595	$17,325	$16,267	$15,852	[P] $15,677
Unemployment rate (percent):					
Total [3]	4.8	8.3	7.0	7.1	6.1
Insured unemployment	3.4	6.0	3.9	2.0	2.5
Income:					
Median family income (constant 1986 dollars)	$27,862	$27,949	$27,974	$28,269	NA
GNP (billions):					
Current dollars	$1,016	$1,598	$2,732	$3,998	[P] $4,486.2
Constant 1982 dollars	$2,416	$2,695	$3,187	$3,585	[P] $3,819.6
Wages and salaries as a percent of GNP	54	51	50	49	[P] 49

[1] Includes overtime.

[2] Full-year equivalent for total private nonagricultural workers.

[3] Percent of total labor force, including Armed Forces residing in the United States.

[P] Preliminary.

NA—Not available.

TABLE 2.—MONTHLY DATA FOR CPI–U SINCE 1970

CPI–U: All Items (1967=100)

Year	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	CY	FY Avg.
1970	113.3	113.9	114.5	115.2	115.7	116.3	116.7	116.9	117.5	118.1	118.5	119.1	116.3	113.2
1971	119.2	119.4	119.8	120.2	120.8	121.5	121.8	122.1	122.2	122.4	122.6	123.1	121.3	119.0
1972	123.2	123.8	124.0	124.3	124.7	125.0	125.5	125.7	126.2	126.6	126.9	127.3	125.3	123.3
1973	127.7	128.6	129.8	130.7	131.5	132.4	132.7	135.1	135.5	136.6	137.6	138.5	133.1	128.3
1974	139.7	141.5	143.1	143.9	145.5	146.9	148.0	149.9	151.7	153.0	154.3	155.4	147.7	139.7
1975	156.1	157.2	157.8	158.6	159.3	160.6	162.3	162.8	163.6	164.6	165.6	166.3	161.2	155.2
1976	166.7	167.1	167.5	168.2	169.2	170.1	171.1	171.9	172.6	173.3	173.8	174.3	170.5	166.2
1977	175.3	177.1	178.2	179.6	180.6	181.8	182.6	183.3	184.0	184.5	185.4	186.1	181.5	178.7
1978	187.2	188.4	189.8	191.5	193.3	195.3	196.7	197.8	199.3	200.9	202.0	202.9	195.4	191.3
1979	204.7	207.1	209.1	211.5	214.1	216.6	218.9	221.1	223.4	225.4	227.5	229.9	217.4	211.1
1980	233.2	236.4	239.8	242.5	244.9	247.6	247.8	249.4	251.7	253.9	256.2	258.4	246.8	239.7
1981	260.5	263.2	265.1	266.8	269.0	271.3	274.4	276.5	279.3	279.9	280.7	281.5	272.4	266.2
1982	282.5	283.4	283.1	284.3	287.1	290.6	292.2	292.8	293.3	294.1	293.6	292.4	289.1	280.0
1983	293.1	293.2	293.4	295.5	297.1	298.1	299.3	303.3	301.8	302.6	303.1	303.5	298.4	296.0
1984	305.2	306.6	307.3	308.8	309.7	310.7	311.7	313.0	314.5	315.3	315.3	315.5	311.1	308.1
1985	316.1	317.4	318.8	320.1	321.3	322.3	322.8	323.5	324.5	325.5	326.6	327.4	322.2	319.4
1986	328.4	327.5	326.0	325.3	326.3	327.9	328.0	328.6	330.2	330.5	330.8	331.1	328.4	327.3
1987	331.1	334.4	335.9	337.7	338.7	340.1	340.8	342.7	344.4	345.3	345.8	345.7	340.4	336.8

TABLE 3.—POPULATION STATISTICS BY STATE

State	Resident population July 1, 1986 (thousands)[1]	Resident population July 1, 1985 (thousands)	Population 65 years and over (thousands)	Percentage of population over age 65	Percentage change 1980–84[2]	Percentage change 1970–80
Total	241,078	238,291	28,040	11.9	4.2	11.4
Connecticut	3,189	3,174	407	12.9	2.1	2.5
Maine	1,173	1,164	152	13.1	3.5	13.2
Massachusetts	5,832	5,882	777	13.4	1.5	0.8
New Hampshire	1,027	998	114	11.7	8.4	24.8
Rhode Island	975	968	138	14.3	2.2	−0.3
Vermont	541	535	63	11.8	4.6	15.0
Delaware	633	622	67	11.0	4.6	8.4
District of Columbia	626	626	75	12.1	−2.0	−15.6
Maryland	4,463	4,392	447	10.3	4.2	7.5
New Jersey	7,619	7,562	942	12.5	2.7	2.7
New York	17,772	17,783	2,247	12.7	1.3	−3.7
Pennsylvania	11,888	11,853	1,676	14.1	−0.1	0.5
Illinois	11,552	11,535	1,356	11.8	0.9	2.8
Indiana	5,504	5,499	638	11.6	0.2	5.7
Michigan	9,145	9,088	1,007	11.1	−1.9	4.3
Ohio	10,752	10,744	1,280	11.9	−0.5	1.3
Wisconsin	4,785	4,775	611	12.8	1.5	6.5
Iowa	2,851	2,884	410	14.1	−1.0	3.1
Kansas	2,460	2,450	323	13.3	3.7	5.1
Minnesota	4,214	4,193	517	12.4	2.9	7.1
Missouri	5,066	5,029	682	13.6	2.3	5.1
Nebraska	1,598	1,606	216	13.4	2.3	5.7
North Dakota	679	685	87	12.6	4.9	5.7
South Dakota	708	708	96	13.6	2.5	3.7
Alabama	4,052	4,021	476	11.9	3.3	13.1
Arkansas	2,372	2,359	336	14.3	3.2	18.9
Florida	11,675	11,366	1,931	17.6	16.6	43.5
Georgia	6,104	5,976	577	9.9	9.4	19.1
Kentucky	3,729	3,726	438	11.8	1.8	13.7
Louisiana	4,501	4,481	435	9.7	6.5	15.4
Mississippi	2,625	2,613	306	11.8	3.7	13.7
North Carolina	6,333	6,255	688	11.2	6.4	15.7
South Carolina	3,377	3,347	331	10.0	7.2	20.5
Tennessee	4,803	4,762	566	12.0	3.7	16.9
Virginia	5,787	5,706	572	10.2	6.7	14.9
West Virginia	1,918	1,936	255	13.0	−0.7	11.8
Arizona	3,319	3,187	375	12.3	17.2	53.1
New Mexico	1,479	1,450	135	9.5	11.3	28.1

TABLE 3.—POPULATION STATISTICS BY STATE—Continued

State	Resident population July 1, 1986 (thousands) [1]	Resident population July 1, 1985 (thousands)	Population 65 years and over (thousands)	Percentage of population over age 65	Percentage change 1980–84 [2]	Percentage change 1970–80
Oklahoma	3,305	3,301	401	12.1	9.1	18.2
Texas	16,685	16,370	1,514	9.5	15.0	27.1
Colorado	3,267	3,231	280	8.8	11.8	30.8
Idaho	1,002	1,005	108	10.8	6.4	32.4
Montana	819	826	96	11.6	5.0	13.3
Utah	1,665	1,645	128	7.7	12.6	37.9
Wyoming	507	509	42	8.2	8.5	41.3
California	26,981	26,365	2,693	10.5	11.4	18.5
Nevada	963	936	87	9.5	16.9	63.8
Oregon	2,698	2,687	344	12.9	2.1	25.9
Washington	4,462	4,409	492	11.3	6.7	21.1
Alaska	534	521	15	3.1	29.7	32.8
Hawaii	1,062	1,054	94	9.0	9.2	25.3

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[1] Preliminary.

[2] Figures revised, December 1985.

Source: U.S. Department of Commerce, Bureau of the Census, Population Estimates and Projections, Series P–25, No. 957, Press Release CB84–233, and unpublished records.

TABLE 4.—INCOME, POVERTY AND UNEMPLOYMENT STATISTICS BY STATE

State	1986 per capita personal income [1] [2]	1984 per capita personal income [2]	Rank 1984 [2]	1987 unemployment rate [3] (percent)	Poverty rate 1969 [4]	Poverty rate 1975 [5]	Poverty rate 1979 [6]
Total			6.1	13.7	11.4	12.4	
Connecticut	19,208	16,556	2	3.3	7.2	6.7	8.0
Maine	12,709	10,813	37	4.4	13.6	12.0	13.0
Massachusetts	17,516	14,784	4	3.2	8.6	7.1	9.6
New Hampshire	15,922	13,192	15	2.5	9.1	7.9	8.5
Rhode Island	14,670	12,820	17	3.8	11.0	8.7	10.3
Vermont	12,845	10,802	39	3.6	12.1	13.5	12.0
Delaware	15,010	13,685	10	3.2	10.9	8.2	11.8
District of Columbia	18,980	17,113	...	6.3	17.0	12.5	18.6
Maryland	16,588	14,464	6	4.2	10.1	7.7	9.8
New Jersey	18,284	15,440	3	4.0	8.1	8.1	9.5
New York	17,118	14,318	7	4.9	11.1	9.4	13.4
Pennsylvania	13,944	12,314	26	5.7	10.6	9.7	10.5
Illinois	15,420	13,802	9	7.4	10.2	10.5	11.0

TABLE 4.—INCOME, POVERTY AND UNEMPLOYMENT STATISTICS BY STATE—Continued

State	1986 per capita personal income[1] [2]	1984 per capita personal income [2]	Rank 1984 [2]	1987 unemployment rate [3] (percent)	Poverty rate		
					1969 [4]	1975 [5]	1979 [6]
Indiana	12,944	11,717	31	6.4	9.7	8.1	9.7
Michigan	14,064	12,607	20	8.2	9.4	9.1	10.4
Ohio	13,743	12,355	24	7.0	10.0	9.4	10.3
Wisconsin	13,796	12,474	22	6.1	9.8	7.7	8.7
Iowa	13,222	12,160	28	5.5	11.6	7.9	10.1
Kansas	14,379	13,248	13	4.9	12.7	8.0	10.1
Minnesota	14,737	13,247	14	5.4	10.7	8.3	9.5
Missouri	13,657	12,151	29	6.3	14.7	12.0	12.2
Nebraska	13,777	12,430	23	6.3	13.1	9.6	10.7
North Dakota	12,284	12,352	25	5.2	15.7	10.6	12.6
South Dakota	11,850	11,069	35	4.2	18.7	13.1	16.9
Alabama	11,115	9,992	46	7.8	25.4	16.4	18.9
Arkansas	10,773	9,805	47	8.1	27.8	18.5	19.0
Florida	14,281	12,763	19	5.3	16.4	14.4	13.4
Georgia	13,224	11,551	34	5.5	20.7	18.0	16.6
Kentucky	11,129	10,300	42	8.8	22.9	17.7	17.6
Louisiana	11,227	10,808	38	12.0	26.3	19.3	18.6
Mississippi	9,552	8,777	50	10.2	35.4	26.1	23.9
North Carolina	12,245	10,850	36	4.5	20.3	14.7	14.8
South Carolina	11,096	10,116	44	5.6	23.9	17.2	16.6
Tennessee	11,831	10,419	41	8.4	21.8	15.8	16.4
Virginia	15,374	13,254	12	4.2	15.5	10.5	11.8
West Virginia	10,530	9,728	49	10.8	22.2	15.1	15.0
Arizona	13,220	11,841	30	6.2	15.3	13.8	13.2
New Mexico	11,037	10,262	43	8.9	22.8	19.3	17.6
Oklahoma	12,368	11,655	32	7.4	18.8	13.8	13.4
Texas	13,523	12,572	21	8.4	18.8	15.2	14.7
Colorado	15,113	13,847	8	7.7	12.3	9.1	10.1
Idaho	11,432	10,092	45	8.0	13.2	10.3	12.6
Montana	11,904	10,546	40	7.4	13.6	11.5	12.3
Utah	10,743	9,733	48	6.4	11.4	8.5	10.3
Wyoming	13,230	12,224	27	8.6	11.7	8.7	7.9
California	16,778	14,487	5	5.8	11.1	10.4	11.4
Nevada	15,074	13,320	11	6.3	9.1	8.8	8.7
Oregon	13,217	11,611	33	6.2	11.5	8.9	10.7
Washington	14,498	12,792	18	7.6	10.2	8.5	9.8
Alaska	17,744	17,487	1	10.8	12.6	6.7	10.7
Hawaii	14,691	13,042	16	3.8	9.3	7.9	9.9

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[1] Preliminary.

[2] U.S. Department of Commerce, Bureau of Economic Analysis.

[3] U.S. Department of Labor, Bureau of Labor Statistics, Current Population Survey.

[4] U.S. Bureau of the Census, Statistical Abstract of the United States: 1979, table 764, pp. 465 (100th edition), Washington, D.C. 1979. 1969 estimates are from the 1970 census.

[5] Data are also from the 1979 Statistical Abstract of the United States, but estimates are from the Survey of Income and Education.

[6] U.S. Bureau of the Census, Statistical Abstract of the United States: 1982–83, table 732, p. 443. (103d edition.) Washington, D.C. 1982. 1979 estimates are from the 1980 census.

TABLE 5.—POPULATION BY AGE GROUPS, 1940–86, SELECTED YEARS

[Thousands of persons]

July 1	Total	Age (years)				
		16–19	20–24	25–44	45–64	65 and over
1940	132,122	9,895	11,690	39,868	26,249	9,031
1945	139,928	9,361	12,036	42,521	28,630	10,494
1950	152,271	8,542	11,680	45,672	30,849	12,397
1955	165,931	8,744	10,714	47,194	33,506	14,525
1960	180,671	10,683	11,134	47,140	36,203	16,675
1965	194,303	13,516	13,746	46,912	38,916	18,451
1970	205,052	15,289	17,202	48,473	41,999	20,107
1971	207,661	15,688	18,159	48,936	42,482	20,561
1972	209,896	16,039	18,153	50,482	42,898	21,020
1973	211,909	16,446	18,521	51,749	43,235	21,525
1974	213,854	16,769	18,975	53,051	43,522	22,061
1975	215,973	17,017	19,527	54,302	43,801	22,696
1976	218,035	17,194	19,986	55,852	44,008	23,278
1977	220,239	17,276	20,499	57,561	44,150	23,892
1978	222,585	17,288	20,946	59,400	44,286	24,502
1979	225,055	17,242	21,297	61,379	44,390	25,134
1980	227,757	17,160	21,584	63,494	44,515	25,704
1981	230,138	16,770	21,821	65,619	44,569	26,236
1982	232,520	16,255	21,807	67,856	44,601	26,827
1983	234,799	15,704	21,700	69,970	44,678	27,428
1984	237,001	15,141	21,536	72,048	44,817	27,973
1985	239,283	14,819	21,214	74,076	44,931	28,536
1986	241,596	14,802	20,613	76,126	45,053	29,173

Note: Includes Armed Forces overseas. Alaska and Hawaii beginning 1950.

Source: Department of Commerce, Bureau of the Census.

TABLE 6.—PROJECTIONS OF THE RESIDENT POPULATION OF THE UNITED STATES, BY AGE AND SEX: 1980 TO 2000

[In thousands as of July 1, except as noted]

Age (years)	Both sexes			Female		
	Census, (April 1, 1980)	Projections		Census (April 1, 1980)	Projections	
		1990	2000		1990	2000
Total, all ages	226,546	249,134	267,432	116,493	128,089	137,414
15 to 19	21,168	16,916	18,891	10,413	8,294	9,257
20 to 24	21,319	18,360	16,925	10,655	9,111	8,396
25 to 29	19,521	21,410	17,284	9,816	10,632	8,579
30 to 34	17,561	21,939	18,951	8,884	10,991	9,430
35 to 39	13,965	19,955	21,707	7,104	10,067	10,827
40 to 44	11,669	17,827	21,971	5,961	9,048	11,049
45 to 49	11,090	13,975	19,758	5,702	7,148	10,024
50 to 54	11,710	11,421	17,355	6,089	5,903	8,899
55 to 59	11,615	10,433	13,280	6,133	5,479	6,917
60 to 64	10,088	10,618	10,487	5,418	5,701	5,578
65 to 69	8,782	9,996	9,096	4,880	5,538	4,989
70 to 74	6,798	8,039	8,581	3,945	4,634	4,916
75 to 79	4,794	6,260	7,295	2,946	3,825	4,426
80 to 84	2,935	4,089	5,023	1,916	2,669	3,252
85 and over	2,240	3,313	4,926	1,559	2,393	3,576

Source: Bureau of the Census, Population Estimates and Projections, Series P-25, No. 952.

TABLE 7.—PERCENT OF SELECTED POPULATION GROUPINGS RECEIVING AFDC, DI, UI AND SSI BY REGION/STATE

	Percent of children on AFDC 1984	Percent of people age 25–64 on DI 1985	Percent of people age 25–64 on UI 1985	Percent of people age 25–64 on SSI 1985
New England:				
Maine	10.5	2.6	2.5	2.4
New Hampshire	4.0	1.8	1.0	0.8
Vermont	9.9	2.2	1.9	2.3
Massachusetts	11.2	1.9	2.2	1.8
Rhode Island	12.4	2.8	3.0	2.1
Connecticut	10.9	1.7	1.8	1.2
Middle Atlantic:				
New York	16.6	2.2	2.2	2.6
New Jersey	13.3	2.0	2.4	1.6
Pennsylvania	12.9	2.3	2.8	1.9
East North Central:				
Ohio	14.6	2.3	2.0	1.8
Indiana	7.3	2.3	1.5	1.3
Illinois	15.9	1.8	2.3	1.7
Michigan	18.3	2.4	1.9	2.0

TABLE 7.—PERCENT OF SELECTED POPULATION GROUPINGS RECEIVING AFDC, DI, UI AND SSI BY REGION/STATE—Continued

	Percent of children on AFDC 1984	Percent of people age 25–64 on DI 1985	Percent of people age 25–64 on UI 1985	Percent of people age 25–64 on SSI 1985
Wisconsin	13.5	2.1	2.3	2.0
West North Central:				
Minnesota	7.9	1.5	1.8	1.1
Iowa	9.7	1.9	1.9	1.3
Missouri	9.6	2.5	1.8	2.0
North Dakota	3.8	1.6	1.6	1.3
South Dakota	5.5	1.9	1.0	1.6
Nebraska	6.2	1.7	1.6	1.3
Kansas	6.8	1.7	1.7	1.3
South Atlantic:				
Delaware	10.7	2.3	1.2	1.6
Maryland	11.4	1.6	1.5	1.6
District of Columbia	33.9	1.7	2.4	3.4
Virginia	7.3	2.1	0.8	1.8
West Virginia	11.7	3.7	2.3	3.3
North Carolina	6.9	2.7	1.8	2.5
South Carolina	9.1	2.9	2.2	3.0
Georgia	10.1	2.7	1.4	3.0
Florida	7.6	2.4	1.2	1.8
East South Central:				
Kentucky	10.1	3.2	1.8	3.4
Tennessee	8.3	2.8	1.9	3.2
Alabama	9.4	3.0	2.1	3.4
Mississippi	14.1	3.7	2.5	4.9
West South Central:				
Arkansas	6.8	3.6	2.1	3.4
Louisiana	11.5	2.5	3.1	3.5
Oklahoma	6.0	2.0	1.6	2.1
Texas	5.0	1.4	1.2	1.6
Mountain:				
Montana	5.7	2.1	1.8	1.4
Idaho	3.6	1.8	2.7	1.3
Wyoming	3.6	1.2	1.4	0.6
Colorado	6.4	1.4	1.6	1.2
New Mexico	7.8	2.0	1.8	2.4
Arizona	5.9	2.2	1.5	1.4
Utah	4.0	1.2	1.3	0.9
Nevada	3.8	1.8	1.9	0.7
Pacific:				
Washington	8.9	1.8	2.7	1.6
Oregon	6.6	2.1	2.9	1.3
California	15.5	1.8	2.7	2.9
Alaska	6.2	0.7	4.6	0.8
Hawaii	11.8	1.3	1.9	1.2
National totals	11.3	2.2	2.1	2.1

Source: AFDC (Aid to Families with Dependent Children): Social Security Bulletin, July 1986, Table M-29; Bureau of the Census, Series P-25, No. 998, Table 4 (July 4, 1984).

DI (Disability Insurance): Social Security Bulletin, December 1986, Table Q-10; Bureau of the Census, Series P-25, No. 998, Table 4 (July 1, 1985).

UI (Unemployment Insurance): Social Security Bulletin, June 1986, Table M-35; Bureau of the Census Series P-25, No. 998, Table 4 (July 1, 1985).

SSI (Supplemental Security Income): Office of Supplemental Security Income, Social Security Administration; Bureau of the Census, Series P-25, No. 998, Table 4 (July 1, 1985).

STATE FISCAL CAPACITY ESTIMATES FOR 1985

Each year the Advisory Commission on Intergovernmental Relations (ACIR) tabulates the State-local government revenue collected in each State and estimates the revenue capacity in each State. Tables 8 and 9 summarize the ACIR figures for 1985.

Table 8 summarizes the total amount of revenue collected by State-local governments in 1985. State-local governments collected $428.1 billion in revenue, which is about 54 percent of the revenue collected by the Federal Government in 1985 and 9.3 percent of the Gross National Product (GNP). Four revenue sources account for 91 percent of State-local government revenue: sales taxes at 28.4 percent; property taxes at 24.3 percent; income taxes at 20.8 percent; and user charges at 17.4 percent.

Table 9 summarizes the ACIR estimates of State fiscal capacity and provides an index of fiscal effort in each State. The first column shows the actual revenue collected by State-local governments in each State during 1985. Ohio, for example, collected about $17.6 billion in State-local revenue in 1985.

The second column of table 9 shows the estimated fiscal capacity in each State under what ACIR calls the "representative revenue system" (RRS). The RRS applies the national average State tax rate, license fee, user charge, etc., to the respective estimated revenue sources in each State. The result is a measure of revenue each State would collect if it used all 30 revenue sources in the RRS and applied the national average State rates or charges to each source. Ohio, for example, had a revenue capacity of $17.5 billion under the RRS.

The third column provides an index of fiscal effort in each State. It is the ratio of revenue collected to revenue capacity expressed as a percent. A State that collects about as much revenue as its revenue capacity will have a ratio around 100. Ohio, for example, has a ratio of 100.2. A State that collects less revenue than its revenue capacity will have an index below 100 and a State that collects more than its revenue capacity will have an index above 100. The District of Columbia had the highest revenue effort at 124.5 and New Hampshire the lowest revenue effort at 66.4.

TABLE 8.—STATE AND LOCAL GOVERNMENT REVENUE IN 1985

Revenue bases	State-local revenue in billions of dollars	State-local revenue: share of total in percent
General sales and gross receipts taxes	$84.2	19.7
Selective sales taxes	37.4	8.7
Parimutuel	0.7	0.2
Motor fuel	13.6	3.2
Insurance	4.5	1.1
Tobacco	4.4	1.0
Amusement	0.5	0.1
Public utilities	10.3	2.4
Distilled spirits	1.7	0.4
Beer	1.3	0.3
Wine	0.3	0.1
License taxes	11.8	2.8
Vehicle operator	0.6	0.1
Corporation	2.8	0.7
Hunting and fishing	0.6	0.1
Alcoholic beverages	0.2	0.1
Automobile	4.5	1.1
Truck	3.1	0.7
Personal income taxes	70.1	16.4
Corporate income taxes	19.0	4.4
Property taxes	103.9	24.3
Residential	63.1	14.7
Farm	4.4	1.0
Commercial/industrial	27.6	6.4
Public utilities	8.8	2.1
Estate and gift taxes	2.4	0.6
Severance taxes	7.5	1.8
Oil and gas	6.6	1.5
Coal	0.6	0.1
Nonfuel mineral	0.2	0.0
Other taxes	13.7	3.2
Rents and royalties	3.2	0.7
Mineral leasing	0.5	0.1
User charges	74.5	17.4
Total	428.1	100.0

Source: Advisory Commission on Intergovernmental Relations, Measuring State Fiscal Capacity, 1987 Edition, p. 5.

TABLE 9.—STATE FISCAL CAPACITY ESTIMATES FOR THE REPRESENTATIVE REVENUE SYSTEM IN 1985

[Dollar amount in millions]

State	Revenue collected	Estimated revenue capacity	Ratio of revenue collected to revenue capacity (percent)
Alabama	$5,570	$5,417	102.8
Alaska	4,320	3,577	120.8
Arizona	5,241	5,529	94.8
Arkansas	2,841	3,110	91.4
California	53,094	56,452	94.1
Colorado	5,916	6,695	88.4
Connecticut	6,424	7,189	89.4
Delaware	1,265	1,315	96.2
D.C.	1,722	1,383	124.5
Florida	17,509	20,671	84.7
Georgia	9,591	9,597	99.9
Hawaii	2,079	2,131	97.6
Idaho	1,319	1,407	93.7
Illinois	19,549	20,171	96.9
Indiana	8,363	8,556	97.7
Iowa	4,917	4,388	112.1
Kansas	4,121	4,304	95.7
Kentucky	4,658	5,178	90.0
Louisiana	7,750	7,879	98.4
Maine	1,788	1,831	97.7
Maryland	8,263	8,316	99.4
Massachusetts	11,479	11,783	97.4
Michigan	18,027	15,356	117.4
Minnesota	9,207	7,559	121.8
Mississippi	3,383	3,183	106.3
Missouri	6,815	8,181	83.3
Montana	1,390	1,322	105.1
Nebraska	2,657	2,686	98.9
Nevada	1,785	2,294	77.8
New Hampshire	1,310	1,972	66.4
New Jersey	15,273	15,918	95.9
New Mexico	2,562	2,797	91.6
New York	47,349	32,858	144.1
North Carolina	8,746	9,523	91.8
North Dakota	1,320	1,241	106.4
Ohio	17,550	17,511	100.2
Oklahoma	5,422	5,987	90.6

TABLE 9.—STATE FISCAL CAPACITY ESTIMATES FOR THE REPRESENTATIVE REVENUE SYSTEM IN 1985—Continued

[Dollar amount in millions]

State	Revenue collected	Estimated revenue capacity	Ratio of revenue collected to revenue capacity (percent)
Oregon	4,748	4,484	105.9
Pennsylvania	18,905	19,156	98.7
Rhode Island	1,673	1,556	107.5
South Carolina	4,666	4,565	102.2
South Dakota	922	1,032	89.3
Tennessee	6,212	7,011	88.6
Texas	25,820	31,908	80.9
Utah	2,614	2,387	109.5
Vermont	891	905	98.5
Virginia	9,248	10,064	91.9
Washington	7,879	7,896	99.8
West Virginia	2,791	2,628	106.2
Wisconsin	9,371	7,627	122.9
Wyoming	1,829	1,654	110.6
United States	428,144	428,140	100.0

Source: Advisory Commission on Intergovernmental Relations, Measuring State Fiscal Capacity, 1987 Edition, p. 71.

APPENDIX K. QUALITY CONTROL SYSTEMS

In the four major welfare programs, AFDC, SSI, Medicaid, and the food stamp program, the Federal Government and the States have established on-going "quality control" systems. These systems have two goals: correcting faults in program administration that contribute to erroneous payments and reducing the extent of misspent benefit dollars. To these ends, they attempt to: (1) measure the extent and dollar value of "errors" in administration; (2) identify the types and causes of error; and (3) specify and monitor corrective actions taken to eliminate or reduce errors.

Fiscal incentives and sanctions have also been made a part of these systems. States can be held liable for the cost of benefit payments made in excess of federally established error tolerance levels, often referred to as target error rates, or (in the food stamp program) they may be sanctioned by the loss of a portion or all of the Federal share of their food stamp administrative expenses. The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) included target error rates for AFDC and Medicaid; the 1982 Omnibus Budget Reconciliation Act (P.L. 97-253) also established target error rates for the food stamp program. The AFDC target error rate for fiscal year 1983 was 4 percent, and was reduced to 3 percent for fiscal year 1984 and thereafter. For Medicaid, a 3-percent target error rate was established for quarters beginning after March 30, 1983. Under Medicaid, prospective fiscal sanctions were authorized to be applied beginning in the second half of fiscal year 1983 for States with error rates exceeding 3 percent. However, errors, which, if corrected, would not have made a difference in the amount of medical assistance paid, are excluded from the calculation.

Under the food stamp law which became effective at the start of fiscal year 1983, States were required to reduce their error rates by one-third each year, but they also were required to reach 5 percent by fiscal year 1985.

For AFDC and Medicaid there are no longer any fiscal incentive provisions except in Guam, Puerto Rico, and the Virgin Islands. For food stamps, the incentive provision is an increase from 50 percent to 60 percent in the Federal share of administrative costs for States with error rates of 5 percent or less.

MEASUREMENT OF ERROR

The core of the four existing quality control systems is the quality control case survey. Each system compiles the results of a randomly selected, statistically valid, sample of cases ranging from 40,000 to 80,000 nationwide. For AFDC, food stamps, and SSI, the cases are now selected, and error data compiled, on an annual basis rather than every 6 months as is the case in Medicaid. In the past, AFDC, food stamps, and SSI programs also collected quality control data every 6 months. Each selected case is subjected to a thorough review by quality control personnel, including a full field investigation. This review identifies payments to ineligibles, overpayments, underpayments, the type of error made, the responsibility (recipient versus administering agency) for the error, and, to a limited degree, incorrect denials of aid. Error "rates" are then established for that review period for each State: "caseload" error rates indicate the proportion of ineligible cases, overpaid cases, underpaid cases, and, in some cases, improperly denied cases in the sample caseload; "payment" error rates indicate the extent of erroneous payments as a proportion of total dollars paid out to the sampled caseload. Moreover, information on the sources and types of errors identified in each quality control review is compiled for use in implementing administrative "corrective actions" intended to reduce or eliminate similar errors in the future.

In the AFDC and food stamp systems, quality control error rates quantify the extent to which eligibility and payment errors exist in the State-administered caseloads of these two programs. In the Medicaid system, quality control error rates indicate the extent to which errors as to eligibility, overpayment, claims processing (payment of improper claims), and identification of third-party liability exist in the Medicaid population. And, in the SSI system, quality control error rates illustrate the extent and cost of errors in the federally administered caseload.

The "errors" identified and measured in all four quality control systems range from simple procedural or arithmetical mistakes, to lack of verification or nonreporting of income, to outright recipient fraud. As a result, although quality control error rates and the information behind them do give a picture of the extent to which improper decisions are being made and help administering agencies pinpoint areas where improvement is needed, they do not represent a statistically accurate measure of intentional actions such as fraud. In fact, "agency-caused" procedural errors make up nearly half the errors typically identified in quality control surveys, and "recipient-caused" errors may often be simple mistakes in understanding what is required or failure to provide correct information on a timely basis.

ADMINISTRATION

In the AFDC, Medicaid, and food stamp programs, the quality control systems are operated by State quality control staff under Federal instructions and guidelines. A State's error rate is determined by using findings from both the State's full sample and a Federal subsample. In the SSI program, the entire quality control system is federally operated since it measures the performance of Federal administration. When identifying errors in food stamp and SSI administration, agency and recipient actions are compared to Federal rules; in the AFDC and Medicaid systems, errors are identified through comparison with State operating policies, the State plan and Federal regulations.

The cost of operating quality control systems is carried as a regular administrative cost and is shared by the States and Federal Government, just as any other administrative expense.

CORRECTIVE ACTION

The basic goal of quality control systems is to reduce, over time, the extent and cost of errors in program administration. As part of each system, "corrective action plans" for error reduction are regularly formulated based on the findings of the quality control sample surveys. Corrective actions can range from personnel policy changes or new computer systems, to substantive changes in eligibility rules or procedures for verifying information provided by recipients. Very often, "error-prone" profiles are drawn up from the results of quality control surveys to assist administrators in identifying cases to which particular attention should be paid.

SANCTIONS AND INCENTIVES

Another use of the results of a quality control sample is to determine the degree to which States will be held financially liable for erroneous payments.

In the AFDC and Medicaid systems, States may be "sanctioned" by being required to pay the Federal Government the Federal cost of improperly issued benefits, as shown by quality control surveys, if they do not keep their error rates below the target rates established by the Tax Equity and Fiscal Responsibility Act for AFDC and Medicaid. The fiscal sanction that may be imposed is the amount of Federal funds misspent above the target error rate. In food stamps, States may be sanctioned through loss of a portion or all of the Federal share of their administrative expenses. However, while fiscal sanctions have been included in legislation prior to the 1982 laws, they have been waived when States demonstrate that they are making a good faith effort to reduce errors. When waivers are not granted, States have begun to appeal the decision to impose sanctions through administrative channels and the courts. In April 1986, as part of the Consolidated Omnibus Budget Reconciliation Act of 1985, a 2-year moratorium was imposed on the collection of AFDC fiscal sanctions (until July 1988). The act requires the Department of Health and Human Services to conduct a study of the AFDC and Medicaid quality control systems for the purposes of restructuring the system as necessary during the moratorium period. The Department is also required to contract with the National Academy of Sciences to conduct an independent study. The National Academy of Sciences report was transmitted to Congress on February 23, 1988.

Table 1 depicts the estimated AFDC sanction amounts and collection schedule according to the Department of Health and Human Services and the Congressional Budget Office. HHS assumes that the entire estimated sanction will be collected beginning in fiscal year 1989. CBO delays collection and assumes that waivers will be granted for some of the estimated sanction amount.

Food stamp program incentive payments are made as increases in the Federal share of State administrative expenses—from the normal 50 percent to 60 percent where the cumulative error rate is less than 5 percent. The food stamp incentive payment requirements also stipulate that the rate of improper denials must fall below a Federal tolerance level in order for an incentive payment to be made on the basis of low or rapidly reducing rates of erroneous payment.

Table 2 summarizes national payment error rates for the four major welfare programs over recent quality control review periods. Table 3 shows the historical trend in the AFDC error rate beginning in 1973.

For AFDC, the national average payment error rate has remained well above the target rate of 3.0 percent. Food stamp program quality control data also show error rates well above the legislated target levels. However, the Medicaid program has shown declining error rates.

TABLE 1.—AFDC SANCTION AMOUNTS AND ESTIMATED COLLECTION SCHEDULE

Year errors were made	Estimated sanction amount (in millions)	HHS and CBO projected schedules for collecting sanctions	
		HHS estimate	CBO estimate
Fiscal year:			
1981	[1] $69		
1982	96		
1983	184		
1984	230		
1985	248	0	0
1986	355	0	0
1987	300	0	0
1988	274	0	0
1989	251	$349	0
1990	222	834	$46
1991	201	825	342
1992	178	222	606
1993	153	201	184
Total	2,761	2,431	1,178

[1] Disallowance notices issued to States. Amount reflects waivers by Secretary of HHS.

Source: Department of Health and Human Services and Congressional Budget Office. Compiled by committee staff.

TABLE 2.—SUMMARY OF NATIONAL OVERPAYMENT ERROR RATES BY PROGRAM

	AFDC	Medicaid[1]	Food stamps[2]	SSI
October 1979–March 1980	8.3	5.2	10.2	5.0
April 1980–September 1980	7.3	5.0	8.9	4.9
October 1980–March 1981	8.3	4.0	10.5	5.3
April 1981–September 1981	7.0	3.0	9.1	4.9
October 1981–March 1982	7.2	2.7	9.9	4.8
April 1982–September 1982	[3] 6.6	2.9	9.2	4.1
October 1982–March 1983	6.2	2.6	8.2	4.1
April 1983–September 1983	6.8	2.9	8.5	3.6
October 1983–March 1984	6.2	2.5	[4] 8.6	[4] 3.3
April 1984–September 1984	5.7	2.9	[4] 8.6	[4] 3.3
October 1984–March 1985	[5] 5.8	NA	NA	[5] 3.3
April 1985–September 1985	[5] 6.5	NA	NA	[5] 3.3
October 1985–September 1986	7.2			

[1] The error rates for the periods between October 1979 and March 1981 have been adjusted to reflect the new payment error rate definition implemented in April 1981.

[2] Overpayment dollar error rate only. Source: Official Federally corrected rates, General Accounting Office.

[3] Estimated.

[4] The food stamps and SSI error rates are no longer calculated for a 6-month period, but for a fiscal year. These statistics are for fiscal year 1984.

[5] These statistics are for fiscal year 1985.

NA = Not available.

Note: Overpayment errors include payments made to ineligible families but does not include underpayments.

Source: Department of Health and Human Services and U.S. Department of Agriculture. Compiled by committee staff.

TABLE 3.—HISTORICAL TRENDS IN THE AFDC ERROR RATE, 1973–85

Period	Percent	Period	Percent
April–September 1973	16.5	October–March 1980	8.3
January–June 1974	14.8	April–September 1980	7.3
July–December 1974	13.6	October–March 1981	8.3
January–June 1975	12.0	April–September 1981	7.0
July–December 1975	10.2	October–March 1982	7.2
January–June 1976	9.6	April–September 1982	6.6
July–December 1976	8.5	October 1982–March 1983	6.2
January–June 1977	8.6	April 1983–September 1983	6.8
July–December 1977	8.7	October 1983–March 1984	6.2
January–June 1978	10.5	April 1984–September 1984	5.7
April–September 1978	9.4	October 1984–March 1985	5.8
October–March 1979	10.4	April 1985–September 1985	6.5
April–September 1979	9.5	October 1985–September 1986	7.2

Source: Department of Health and Human Services, Office of Family Assistance.

HISTORICAL PERSPECTIVE OF QUALITY CONTROL IN THE AFDC PROGRAM

In the early 1960's, as AFDC costs and caseloads began to grow, Congress requested that the Department of Health, Education, and Welfare verify AFDC expenditures. In response to this request, the Department developed an on-going system to validate eligibility and benefits and to serve as a management tool to improve the accuracy of the eligibility and benefit determination process. This evolved into the current quality control system. Table 4 shows State payment errors over time.

In 1973, regulations were issued establishing error tolerance levels of 3 percent on errors resulting from ineligibility and 5 percent on under and overpayments. Any erroneous payments made by the State above these amounts would be disallowed. These tolerances, which were not established by statute, were challenged in court as being arbitrary and capricious by the State of Maryland (*Mathews* v. *Maryland*). The court ruled in Maryland's favor (1978).

On March 7, 1979, the Department issued new regulations establishing error rate limits based on the national average of error rates. The March 7 regulations also included a "good cause" provision enabling the Secretary to waive disallowances based on the State's failure to meet the limit. The March 7 regulation and the threat of disallowances were effective in getting States to implement corrective action. Disallowances were temporarily suspended if States submitted negotiated corrective action plans. No disallowances were taken.

In 1979 the Michel amendment was attached to the Labor, HHS and Education fiscal year 1980 appropriation bill. This amendment requires each State to reach a payment error rate of 4 percent by September 30, 1983. In January 1980 the Department issued the following rules implementing the Michel requirements: States were required to make one-third progress toward the 4 percent goal in fiscal year 1981; two-thirds progress toward the goal in fiscal year 1982; and to attain 4 percent in fiscal year 1983.

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) included further AFDC error rate reduction requirements. TEFRA requires States to move from the 4 percent standard established by the Michel amendment to a 3 percent standard in fiscal year 1984. In addition, the Consolidated Omnibus Budget Reconciliation Act of 1985 established a moratorium on the collection of fiscal sactions. That moratorium expires on July 1, 1988.

Table 4 shows the State error rates for fiscal years 1980–85. States exceeding the target for a given year are indicated. For several years, HHS delayed notifying States of the disallowance amounts for each of these years until new regulations governing the waiver process were issued. However, the regulations were finally issued in proposed form on February 2, 1987; final regulations have not been issued. All States have requested waivers of the penalties for fiscal years 1981–84. HHS has issued decisions only with respect to the fiscal year 1981 penalties.

Columns 1 and 2 of table 5 show State payment error rates and target error rates for fiscal year 1981, the first year the Michel requirements were in effect. Based on these data, 28 States are subject to disallowance for failure to meet their error rate targets for that fiscal year.[1] These are shown in column 3. In March 1983, States were informed of their failure to meet their targets, of the amount of the disallowances, and of the States' right to request a waiver of the disallowance. All 28 States subject to disallowance for failure to meet their fiscal year 1981 targets requested good faith waivers. In April 1986, six States were granted waivers by the HHS Secretary; the remainder have appealed the Secretary's decision to the Grant Appeals Board. Column 4 of table 5 shows the post-waiver disallowance amounts.

TABLE 4.—AFDC ERROR RATES FOR BASE PERIOD AND FISCAL YEARS 1980–85

	April–September 1978	1980	1981	1982	1983	1984	1985
U.S. average	9.4	7.8	7.6	6.9	6.5	6.0	6.1
Alabama	9.5	7.1	[1] 7.7	5.4	3.2	[1] 4.4	[1] 3.8
Alaska	31.2	13.9	18.2	12.1	[1] 15.6	[1] 6.8	[1] 10.5
Arizona [2]	8.0	8.7	[1] 8.3	[1] 11.6	[1] 10.0	[1] 9.7	[1] 8.9
Arkansas	9.1	7.6	6.8	[1] 7.0	[1] 4.8	[1] 3.8	3.0
California	3.7	5.7	[1] 6.8	[1] 6.0	[1] 4.8	[1] 5.0	[1] 5.9
Colorado	4.3	11.6	[1] 8.2	[1] 6.6	[1] 6.2	[1] 4.6	[1] 5.5
Connecticut	8.6	6.3	[1] 7.4	[1] 6.4	[1] 4.4	[1] 3.4	[1] 4.7
Delaware	16.1	8.0	11.3	[1] 11.9	[1] 9.4	[1] 7.8	[1] 7.9
District of Columbia	22.4	12.5	13.6	[1] 17.1	[1] 13.1	[1] 11.2	[1] 9.9
Florida	5.6	6.1	[1] 7.9	[1] 6.0	[1] 4.5	[1] 5.4	[1] 5.7
Georgia	7.8	8.1	6.5	5.1	[1] 5.8	[1] 6.2	[1] 7.6
Hawaii	9.2	9.0	[1] 10.1	[1] 8.2	[1] 6.9	[1] 6.7	[1] 6.3
Idaho	4.4	9.0	[1] 9.1	[1] 5.4	3.0	[1] 9.5	[1] 3.9
Illinois	17.1	8.1	8.3	8.2	[1] 6.8	[1] 6.5	[1] 7.3
Indiana	3.7	4.5	[1] 4.1	3.9	[1] 4.9	[1] 4.0	[1] 4.7
Iowa	7.8	4.2	4.3	4.5	3.4	[1] 3.7	[1] 4.9
Kansas	4.1	5.8	[1] 8.1	2.8	[1] 5.1	[1] 5.5	[1] 5.1
Kentucky	10.2	5.4	5.0	3.6	3.4	[1] 4.1	[1] 3.2
Louisiana	11.1	6.8	6.7	6.2	[1] 5.7	[1] 5.8	[1] 7.2
Maine	9.2	6.6	[1] 7.9	4.1	[1] 4.5	[1] 4.1	[1] 5.7
Maryland [2]	13.6	12.7	[1] 11.6	[1] 8.2	[1] 5.3	[1] 5.7	[1] 7.1
Massachusetts	15.9	12.5	9.3	7.4	[1] 11.4	[1] 7.8	[1] 3.6
Michigan	9.2	7.7	7.3	[1] 8.2	[1] 9.1	[1] 8.0	[1] 6.6
Minnesota	3.4	3.3	[1] 4.4	3.0	2.6	2.0	[1] 2.8
Mississippi	11.6	7.4	6.9	4.7	3.5	2.0	2.8
Missouri	10.1	7.3	7.1	4.8	3.4	[1] 3.7	[1] 3.9

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[1] The fiscal year 1984 appropriation legislation suggested that no sanctions be taken until a major review of the quality control program is carried out; the Department was proceeding with the sanctioning process.

TABLE 4.—AFDC ERROR RATES FOR BASE PERIOD AND FISCAL YEARS 1980–85—Continued

	April–September 1978	1980	1981	1982	1983	1984	1985
Montana	9.7	10.2	4.9	2.5	2.5	[1] 6.9	[1] 7.5
Nebraska	4.6	4.9	[1] 5.5	[1] 9.6	[1] 4.7	[1] 6.9	[1] 7.9
Nevada	0.6	1.2	2.3	1.3	2.7	2.1	2.6
New Hampshire	11.0	11.0	6.6	5.9	[1] 4.3	[1] 7.5	[1] 5.2
New Jersey [2]	9.3	10.4	[1] 8.0	[1] 7.3	[1] 6.4	[1] 5.1	[1] 6.3
New Mexico	4.8	7.3	[1] 12.4	[1] 10.5	[1] 6.1	[1] 6.2	[1] 5.7
New York	8.8	8.3	[1] 8.0	[1] 8.0	[1] 9.4	[1] 7.1	[1] 7.4
North Carolina	7.9	5.6	5.4	3.3	2.7	[1] 3.5	2.2
North Dakota	1.6	6.0	3.1	1.9	2.1	[1] 4.7	1.2
Ohio	9.5	8.7	[1] 8.9	[1] 7.6	[1] 5.6	[1] 6.4	[1] 6.6
Oklahoma	3.2	4.4	[1] 6.6	3.8	[1] 4.1	3.0	2.8
Oregon	12.7	4.5	6.8	6.4	[1] 5.5	[1] 4.6	[1] 3.8
Pennsylvania	16.3	9.8	9.0	[1] 8.5	[1] 9.1	[1] 9.1	[1] 6.6
Rhode Island	12.7	8.9	6.3	5.7	[1] 6.2	[1] 3.7	[1] 4.6
South Carolina [2]	7.1	7.3	[1] 7.8	[1] 8.9	[1] 7.1	[1] 7.8	[1] 7.0
South Dakota	4.8	5.2	[1] 4.6	3.7	2.1	2.9	1.5
Tennessee	7.0	7.0	[1] 8.9	4.9	[1] 4.3	[1] 4.3	[1] 3.4
Texas	6.9	7.6	[1] 7.5	[1] 8.4	[1] 7.0	[1] 5.7	[1] 4.3
Utah [2]	2.8	7.1	[1] 4.9	[1] 5.0	[1] 5.7	[1] 5.8	[1] 4.5
Vermont [2]	4.5	11.4	[1] 5.2	[1] 4.5	[1] 7.9	[1] 5.8	[1] 5.7
Virginia	11.7	5.0	3.6	4.1	3.8	[1] 3.5	[1] 3.6
Washington	6.7	9.0	[1] 9.3	[1] 6.4	[1] 4.8	[1] 4.1	[1] 5.1
West Virginia	11.3	6.1	7.4	[1] 8.2	3.0	4.8	[1] 5.8
Wisconsin	11.1	7.9	8.2	[1] 6.5	[1] 5.1	[1] 6.6	[1] 8.6
Wyoming	4.0	13.8	[1] 13.7	[1] 4.8	[1] 7.7	[1] 5.6	[1] 3.0
Puerto Rico	7.8	7.6	[1] 8.9	[1] 8.9	[1] 8.6	[1] 7.7	[1] 6.3
Guam	NA	NA	NA	NA	[1] 19.7	[1] 21.9	[1] 14.2
Virgin Islands	11.2	NA	6.9	4.6	[1] 8.6	2.4	[1] 3.0
Total subject to disallowance			28	28	40	49	46

[1] Error rate exceeds target.

[2] Granted waiver of fiscal year 1981 disallowance.

Source: Department of Health and Human Services, Office of Family Assistance.

TABLE 5.—AFDC ERROR AND TARGET RATES FOR FISCAL YEAR 1981 AND POTENTIAL DISALLOWANCE AMOUNTS

	Fiscal year 1981 [1]	Target rate	Potential disallowance amount (thousands)	Post-waiver disallowance amount (thousands)
U.S. average	7.6		$73,502	$69,159
Alabama	7.7	7.6	47	47
Alaska	18.2	22.1		
Arizona	8.3	6.7	209	0
Arkansas	6.8	7.4		
California	6.8	4.0	35,067	35,067
Colorado	8.2	4.2	1,898	1,898
Connecticut	7.4	7.1	313	313
Delaware	11.3	12.0		
District of Columbia	13.6	16.3		
Florida	7.9	5.1	3,467	3,467
Georgia	6.5	6.5		
Hawaii	10.1	7.5	1,212	1,212
Idaho	9.1	4.3	691	691
Illinois	8.3	12.7		
Indiana	4.1	4.0	113	113
Iowa	4.3	6.5		
Kansas	8.1	4.1	1,903	1,903
Kentucky	5.0	8.1		
Louisiana	6.7	8.7		
Maine	7.9	7.5	168	168
Maryland	11.6	10.4	1,325	0
Massachusetts	9.3	11.9		
Michigan	7.3	7.5		
Minnesota	4.4	4.0	571	571
Mississippi	6.9	9.0		
Missouri	7.1	8.1		
Montana	4.9	7.8		
Nebraska	5.5	4.4	280	280
Nevada	2.3	4.0		
New Hampshire	6.6	8.7		
New Jersey	8.0	7.5	1,280	0
New Mexico	12.4	4.5	2,554	2,554
New York	8.0	7.2	6,270	6,270
North Carolina	5.4	6.6		
North Dakota	3.1	4.0		
Ohio	8.9	7.7	3,930	3,930
Oklahoma	6.6	4.0	1,508	1,508

TABLE 5.—AFDC ERROR AND TARGET RATES FOR FISCAL YEAR 1981 AND POTENTIAL DISALLOWANCE AMOUNTS—Continued

	Fiscal year 1981 [1]	Target rate	Potential disallowance amount (thousands)	Post-waiver disallowance amount (thousands)
Oregon	6.8	9.8		
Pennsylvania	9.0	12.2		
Puerto Rico	8.9	6.6	1,714	1,714
Rhode Island	6.3	9.8		
South Carolina	7.8	6.1	1,004	0
South Dakota	4.6	4.5	13	13
Tennessee	8.9	6.0	1,754	1,754
Texas	7.5	5.9	1,112	1,112
Utah	4.9	4.0	300	0
Vermont	5.2	4.3	225	0
Virginia	3.6	9.1		
Washington	9.3	5.8	4,162	4,162
West Virginia	7.4	8.9		
Wisconsin	8.2	8.7		
Wyoming	13.7	4.0	413	413

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[1] Weighted; each 6-month error rate is weighted by the percentage of total annual payments that was expended in that period.

Source: Department of Health and Human Services, Family Support Administration, January 1986.

Table 6 presents similar information for fiscal year 1982. States have been notified of the potential disallowance and have requested waivers. Sanctions will not be collected until the moratorium expires.

TABLE 6.—AFDC QUALITY CONTROL: PAYMENT ERROR RATE, TARGET ERROR RATE, AND POTENTIAL DISALLOWANCE AMOUNTS UNDER MICHEL AMENDMENT, FISCAL YEAR 1982

[Dollars in thousands]

State	Payment error rate		Potential disallowance amount
	Fiscal year 1982	Target rate	
U.S. total	6.9		$95,755
Alabama	5.3	5.8	
Alaska	12.1	13.1	
Arizona	11.6	5.3	1,091
Arkansas	7.0	5.7	323
California	6.0	4.0	27,155
Colorado	6.6	4.1	1,130
Connecticut	6.4	5.5	854
Delaware	11.9	8.0	553
District of Columbia	17.1	10.1	3,014
Florida	6.0	4.5	1,783
Georgia	5.1	5.3	
Hawaii	8.2	5.7	1,084
Idaho	5.4	4.1	169
Illinois	8.2	8.4	
Indiana	3.9	4.0	
Iowa	4.5	5.3	
Kansas	2.8	4.0	
Kentucky	3.6	6.1	
Louisiana	6.2	6.4	
Maine	4.1	5.7	
Maryland	8.2	7.2	1,094
Massachusetts	7.4	8.0	
Michigan	8.2	5.7	13,306
Minnesota	3.0	4.0	
Mississippi	4.7	6.5	
Missouri	4.8	6.0	
Montana	2.5	5.9	
Nebraska	9.6	4.2	1,521
Nevada	1.3	4.0	
New Hampshire	5.9	6.3	
New Jersey	7.3	5.8	4,020
New Mexico	10.5	4.3	1,930
New York	8.0	5.6	19,812
North Carolina	3.3	5.3	
North Dakota	1.9	4.0	
Ohio	7.6	5.8	5,895

TABLE 6.—AFDC QUALITY CONTROL: PAYMENT ERROR RATE, TARGET ERROR RATE, AND POTENTIAL DISALLOWANCE AMOUNTS UNDER MICHEL AMENDMENT, FISCAL YEAR 1982—Continued

[Dollars in thousands]

State	Payment error rate		Potential disallowance amount
	Fiscal year 1982	Target rate	
Oklahoma	3.8	4.0	
Oregon	[1] 6.4	6.9	
Pennsylvania	8.5	8.1	1,797
Puerto Rico	8.9	5.3	1,750
Rhode Island	5.7	6.9	
South Carolina	8.9	5.0	2,072
South Dakota	3.7	4.3	
Tennessee	4.9	5.0	
Texas	8.4	5.0	2,139
Utah	5.0	4.0	325
Vermont	4.5	4.2	94
Virgin Islands	4.6	6.4	
Virginia	4.1	6.6	
Washington	6.4	4.9	1,827
West Virginia	8.2	6.4	691
Wisconsin	6.5	6.4	295
Wyoming	4.8	4.0	33

[1] Revised.

Source: Department of Health and Human Services, Family Support Administration, Office of Family Assistance, January 1987.

Table 7 presents data for fiscal year 1983. Forty States are subject to disallowance for this year.

TABLE 7.—AFDC QUALITY CONTROL PAYMENT ERROR RATES, TARGET ERROR RATE, AND POTENTIAL DISALLOWANCE AMOUNTS UNDER MICHEL AMENDMENT, FISCAL YEAR 1983

[Dollars in thousands]

	Payment error rate		Potential disallowance amount
	Fiscal year 1983	Target rate	
U.S. total	6.5	(1)	$184,244
Alabama	3.2	4.0	
Alaska	15.6	4.0	1,746
Arizona	10.0	4.0	2,366
Arkansas	4.8	4.0	193
California	4.8	4.0	12,631

TABLE 7.—AFDC QUALITY CONTROL PAYMENT ERROR RATES, TARGET ERROR RATE, AND POTENTIAL DISALLOWANCE AMOUNTS UNDER MICHEL AMENDMENT, FISCAL YEAR 1983—Continued

[Dollars in thousands]

	Payment error rate		Potential disallowance amount
	Fiscal year 1983	Target rate	
Colorado	6.2	4.0	1,151
Connecticut	4.4	4.0	436
Delaware	9.4	4.0	731
District of Columbia	13.1	4.0	3,663
Florida	4.5	4.0	726
Georgia	5.8	4.0	2,201
Guam	19.7	4.0	496
Hawaii	6.9	4.0	1,254
Idaho	3.0	4.0	
Illinois	6.8	4.0	11,598
Indiana	4.9	4.0	704
Iowa	3.4	4.0	
Kansas	5.1	4.0	531
Kentucky	3.4	4.0	
Louisiana	5.7	4.0	1,491
Maine	4.5	4.0	245
Maryland	5.3	4.0	1,426
Massachusetts	11.4	4.0	16,577
Michigan	9.1	4.0	29,117
Minnesota	2.6	4.0	
Mississippi	3.5	4.0	
Missouri	3.4	4.0	
Montana	2.5	4.0	
Nebraska	4.7	4.0	209
Nevada	2.7	4.0	
New Hampshire	4.3	4.0	48
New Jersey	6.4	4.0	5,884
New Mexico	6.1	4.0	614
New York	9.4	4.0	47,550
North Carolina	2.7	4.0	
North Dakota	2.1	4.0	
Ohio	5.6	4.0	5,787
Oklahoma	4.1	4.0	26
Oregon	5.5	4.0	769
Pennsylvania	9.1	4.0	21,219
Puerto Rico	8.6	4.0	2,210
Rhode Island	6.2	4.0	857

TABLE 7.—AFDC QUALITY CONTROL PAYMENT ERROR RATES, TARGET ERROR RATE, AND POTENTIAL DISALLOWANCE AMOUNTS UNDER MICHEL AMENDMENT, FISCAL YEAR 1983—Continued

[Dollars in thousands]

	Payment error rate		Potential disallowance amount
	Fiscal year 1983	Target rate	
South Carolina	7.1	4.0	1,656
South Dakota	2.1	4.0	
Tennessee	4.3	4.0	170
Texas	7.0	4.0	2,119
Utah	5.7	4.0	614
Vermont	7.9	4.0	971
Virgin Islands	8.6	4.0	102
Virginia	3.8	4.0	
Washington	4.8	4.0	983
West Virginia	3.0	4.0	
Wisconsin	5.1	4.0	2,966
Wyoming	7.7	4.0	206

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[1] Weighted; each 6-month error rate is weighted by the percentage of total annual payments that was expended in that period.

Finally, table 8 presents quality control and disallowance data for fiscal year 1984. Only 5 States are not subject to fiscal disallowances in fiscal year 1984.

TABLE 8.—AFDC QUALITY CONTROL PAYMENT ERROR RATES, TARGET ERROR RATE, AND POTENTIAL DISALLOWANCE AMOUNTS, FISCAL YEAR 1984

[Dollars in thousands]

	Payment error rates		Potential disallowance amount
	Fiscal year 1984	Target rate	
U.S. total	6.0	(1)	$230,414
Alabama	4.4	3.0	717
Alaska	6.8	3.0	704
Arizona	9.7	3.0	2,846
Arkansas	3.8	3.0	231
California	5.0	3.0	32,344
Colorado	4.6	3.0	868
Connecticut	3.4	3.0	440
Delaware	7.8	3.0	660
District of Columbia	11.2	3.0	3,066
Florida	5.4	3.0	3,412

TABLE 8.—AFDC QUALITY CONTROL PAYMENT ERROR RATES, TARGET ERROR RATE, AND POTENTIAL DISALLOWANCE AMOUNTS, FISCAL YEAR 1984—Continued

[Dollars in thousands]

	Payment error rates		Potential disallowance amount
	Fiscal year 1984	Target rate	
Georgia	6.2	3.0	4,253
Guam	21.9	4.0	639
Hawaii	6.7	3.0	1,513
Idaho	9.5	3.0	900
Illinois	6.5	3.0	14,750
Indiana	4.0	3.0	879
Iowa	3.7	3.0	581
Kansas	5.5	3.0	1,094
Kentucky	4.1	3.0	1,090
Louisiana	5.8	3.0	2,606
Maine	4.1	3.0	559
Maryland	5.7	3.0	3,052
Massachusetts	7.8	3.0	9,674
Michigan	8.0	3.0	30,831
Minnesota	2.0	3.0	
Mississippi	2.0	3.0	
Missouri	3.7	3.0	850
Montana	6.9	3.0	682
Nebraska	6.9	3.0	1,253
Nevada	2.1	3.0	
New Hampshire	7.5	3.0	583
New Jersey	5.1	3.0	5,228
New Mexico	6.2	3.0	1,113
New York	7.1	3.0	39,382
North Carolina	3.5	3.0	500
North Dakota	4.7	3.0	164
Ohio	6.4	3.0	13,602
Oklahoma	3.0	3.0	10
Oregon	4.6	3.0	907
Pennsylvania	9.1	3.0	24,588
Puerto Rico	7.7	4.0	1,789
Rhode Island	3.7	3.0	289
South Carolina	7.8	3.0	2,625
South Dakota	2.9	3.0	
Tennessee	4.3	3.0	747
Texas	5.7	3.0	2,754
Utah	5.8	3.0	993
Vermont	5.8	3.0	784

TABLE 8.—AFDC QUALITY CONTROL PAYMENT ERROR RATES, TARGET ERROR RATE, AND POTENTIAL DISALLOWANCE AMOUNTS, FISCAL YEAR 1984—Continued

[Dollars in thousands]

	Payment error rates		Potential disallowance amount
	Fiscal year 1984	Target rate	
Virgin Islands	2.4	4.0	
Virginia	3.5	3.0	424
Washington	4.1	3.0	1,652
West Virginia	4.8	3.0	957
Wisconsin	6.6	3.0	10,670
Wyoming	5.6	3.0	155

[1] Weighted; each 6-month error rate is weighted by the percentage of total annual payments that was expended in that period.

TYPES OF AFDC ERROR

Tables 9-11 provide detailed information about the kinds of errors States make in administering the AFDC program. Table 9 shows the major types of errors by State. Errors most commonly occur: (1) when determining the countable income of the family and applying the earned income disregards and other requirements related to establishing need and income levels; or (2) when applying basic program requirements—such as verifying age, school attendance, and deprivation—or assuring that procedural requirements are met.

These procedural requirements include noting all social security numbers of family members and filing the paperwork associated with assigning child support rights or registering for WIN. Such paperwork mistakes are known as "technical errors" and are included in the error rate on which fiscal sanctions are based. However, the payment amount does not always change after the technical error is corrected. For example, if a family of three is receiving an AFDC benefit of $325 but is missing one Social Security number in the file, an error has occurred and the family is ineligible for aid because a basic program requirement has not been met. Once the correct Social Security Number has been inserted in the file, however, the family is eligible for the same $325 payment. Table 10 shows the impact of some of these "technical errors" on the official error rate, using fiscal year 1982 data.

Finally, the official error rate includes both agency and client errors. Table 11 shows the percent of total error cases that can be attributed to either the agency or the client as well as the total number of error cases on which these percentages are based. Agency errors can include simple arithmetical mistakes, incorrect policy applications, and inadequate verification. Client errors may be the result of mistakes in understanding, failure to report information on a timely basis or outright recipient fraud. It is not possible to distinguish between these various causes of error using existing quality control data.

TABLE 9.—MAJOR TYPES OF ERRORS BY STATE, OCTOBER 1984–SEPTEMBER 1985 PROGRAM AREA IN ERROR, AS A PERCENT OF TOTAL EXPENDITURES IN ERROR [1]

State	Percent of total expenditures in error				
	Basic program requirements [2]	Resources [3]	Income [4]	Need requirements [5]	Other
Total [6]	39.7	11.3	43.5	4.0	1.4
Alabama	17.3	6.3	76.4		
Alaska	42.6	11.8	45.6		
Arizona	33.5	8.2	54.3	3.2	0.8
Arkansas	36.2	9.6	26.3		2.2
California	41.3	14.7	41.4	2.0	0.6
Colorado	31.7	2.8	63.3	1.8	0.3
Connecticut	35.7	25.7	37.6	0.3	0.7
Delaware	16.6	24.1	53.5		5.7
District of Columbia	26.1		72.0	0.3	1.7
Florida	23.9	8.0	62.5	3.2	2.4
Georgia	18.5	1.1	79.0		1.4
Guam	51.3	19.0	14.7	12.1	2.9
Hawaii	32.7	10.8	42.9	12.4	1.3
Idaho	33.4		43.1	14.4	9.2
Illinois	34.0	4.4	60.8	0.1	0.8
Indiana	32.5	9.4	50.2	6.6	1.3
Iowa	27.2	14.1	56.0	1.6	1.1
Kansas	40.6	18.6	31.7	9.2	
Kentucky	31.7	9.6	53.0	4.6	1.2
Louisiana	20.7	14.4	63.9		1.0
Maine	49.6	14.0	35.5	0.7	0.2
Maryland	30.2	7.9	59.7	0.2	2.0
Massachusetts	19.3	20.6	60.0	0.1	
Michigan	36.0	13.0	33.4	14.4	3.3
Minnesota	41.7	5.8	50.6	0.1	1.7
Mississippi	18.2	22.0	53.7		6.1
Missouri	17.9	14.7	64.5		2.9
Montana	43.4	7.8	40.3		8.5
Nebraska	37.0	5.3	47.9		9.8
Nevada					100.0
New Hamphsire	7.4	18.0	58.6	9.8	6.2
New Jersey	48.4	12.0	38.2		1.5
New Mexico	21.1	15.0	54.1	2.7	7.2
New York	57.2	1.6	27.8	13.1	0.4

TABLE 9.—MAJOR TYPES OF ERRORS BY STATE, OCTOBER 1984–SEPTEMBER 1985 PROGRAM AREA IN ERROR, AS A PERCENT OF TOTAL EXPENDITURES IN ERROR [1]—Continued

State	Percent of total expenditures in error				
	Basic program requirements [2]	Resources [3]	Income [4]	Need requirements [5]	Other
North Carolina	29.3	8.2	59.8		2.8
North Dakota	66.7		33.3		
Ohio	36.5	13.1	49.6	0.1	0.7
Oklahoma	44.3		53.8		1.9
Oregon	23.5	9.8	54.4	5.0	7.3
Pennsylvania	43.9	15.9	38.1	1.3	0.7
Puerto Rico	36.3	2.9	50.5	8.8	1.5
Rhode Island	45.3	31.0	22.6		1.2
South Carolina	29.3	5.6	63.1	0.1	1.8
South Dakota	48.3		30.4	21.3	
Tennessee	34.2	7.4	58.2		0.2
Texas	16.1	15.4	68.4		0.1
Utah	47.9	22.3	28.8	1.0	
Vermont	28.3	25.1	21.8	17.8	7.0
Virgin Islands	22.7	10.3	67.0		
Virginia [7]	29.3	17.0	50.5		3.3
Washington	45.2	11.4	40.0	0.7	2.6
West Virginia	31.0	31.2	31.1	6.3	0.4
Wisconsin	61.6	15.4	21.5		1.5
Wyoming	46.8	9.8	33.6	7.2	2.7

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[1] Includes ineligible and eligible cases receiving incorrect payments.

[2] Basic program requirements: age, school attendance, living with a specified relative, deprivation (incapacity, continued absences, unemployment); WIN program registration, citizenship and alienage, residence, social security number, child support (assignment and cooperation), and monthly report.

[3] Resource items: real property; life insurance; bank deposits or cash on hand; motor vehicle; other.

[4] Income items: earned income, work incentive exemptions; mandatory deductions; work-related expenses; deemed income disregards; RSDI benefits; veterans benefits; unemployment compensation; workmen's compensation; support payment made to IV–D agency contributions; non-earned income disregards; deemed income.

[5] Need requirement items: shelter only, fuel and/or utilities only; basic budgetary allowance(s) other than shelter, fuel and utilities; shelter combined with fuel and/or utilities; shelter and other basic budgetary allowances (excluding fuel and utilities); all basic budgetary allowances (excluding fuel and utilities); all basic budgetary allowances; special diet; transportation; child care; other.

[6] Percentages are weighted by the proportion of each State's average caseload to the national average.

[7] Data incomplete.

Source: Department of Health and Human Services, Family Support Administration, Office of Family Assistance, January 1987.

TABLE 10.—COMPARISON OF OFFICIAL AFDC ERROR RATES WITH PAYMENT ERROR RATES EXCLUDING PROCEDURAL ERRORS, FISCAL YEAR 1982

State	Official error rate	Rate excluding procedural errors [1]	Difference [2]
U.S. total	6.9	5.7	1.2
Alabama	5.3	4.4	0.9
Alaska	12.1	11.8	0.3
Arizona	11.6	10.3	1.3
Arkansas	7.0	6.8	0.2
California	6.0	4.3	1.7
Colorado	6.6	5.6	1.0
Connecticut	6.4	6.0	0.4
Delaware	11.9	9.8	2.0
District of Columbia	17.1	12.9	4.2
Florida	6.0	5.6	0.5
Georgia	5.1	4.9	0.3
Guam			
Hawaii	8.2	7.1	1.1
Idaho	5.4	5.2	0.3
Illinois	8.2	7.1	1.1
Indiana	3.9	3.5	0.4
Iowa	4.5	4.2	0.3
Kansas	2.8	2.7	0.1
Kentucky	3.6	3.0	0.5
Louisiana	6.2	5.6	0.6
Maine	4.1	3.4	0.7
Maryland	8.2	7.2	1.0
Massachusetts	7.4	6.9	0.5
Michigan	8.2	7.5	0.7
Minnesota	3.0	2.8	0.3
Mississippi	4.7	4.6	0.2
Missouri	4.8	4.4	0.4
Montana	2.5	2.5	0.1
Nebraska	9.6	8.7	0.9
Nevada	1.3	1.3	0.0
New Hampshire	5.9	5.7	0.1
New Jersey	7.3	5.3	2.1
New Mexico	10.5	9.7	0.8
New York	8.0	6.6	1.4
North Carolina	3.3	3.0	0.3
North Dakota	1.9	1.9	0.0
Ohio	7.6	5.3	2.3
Oklahoma	3.8	3.3	0.5

TABLE 10.—COMPARISON OF OFFICIAL AFDC ERROR RATES WITH PAYMENT ERROR RATES EXCLUDING PROCEDURAL ERRORS, FISCAL YEAR 1982—Continued

State	Official error rate	Rate excluding procedural errors [1]	Difference [2]
Oregon	7.1	5.9	1.1
Pennsylvania	8.5	7.1	1.5
Puerto Rico	8.9	8.3	0.6
Rhode Island	5.7	4.7	1.0
South Carolina	8.9	7.3	1.6
South Dakota	3.7	3.5	0.2
Tennessee	4.9	3.9	1.0
Texas	8.4	7.6	0.8
Utah	5.0	4.5	0.5
Vermont	4.5	4.4	0.1
Virgin Islands	4.6	3.7	0.8
Virginia	4.1	3.9	0.2
Washington	6.4	6.0	0.4
West Virginia	8.2	6.8	1.4
Wisconsin	6.5	4.6	1.9
Wyoming	4.8	4.5	0.2

[1] Procedural errors include SSN, WIN, and assignment and cooperation of child support rights.
[2] May not add due to rounding.

Source: Department of Health and Human Services, Family Support Administration, Office of Family Assistance.

TABLE 11.—AGENCY AND CLIENT ERRORS, ERROR CASES AS A PERCENT OF TOTAL AFDC ERROR CASES, OCTOBER 1984–SEPTEMBER 1985 [1]

State	Total number of error cases	Percent of total error cases attributed to [2]—	
		Agency	Client
U.S. total [2]	7,558	53.8	46.1
Alabama	85	36.5	63.5
Alaska	59	50.8	49.2
Arizona	156	51.9	48.1
Arkansas	57	35.1	64.9
California	202	61.4	38.6
Colorado [3]	66	42.4	57.6
Connecticut	134	38.8	61.2
Delaware	36	47.2	52.8
District of Columbia	142	45.1	54.9
Florida	259	49.8	50.2
Georgia	178	48.3	51.7

TABLE 11.—AGENCY AND CLIENT ERRORS, ERROR CASES AS A PERCENT OF TOTAL AFDC ERROR CASES, OCTOBER 1984–SEPTEMBER 1985 [1]—Continued

State	Total number of error cases	Percent of total error cases attributed to [2]—	
		Agency	Client
Guam	69	73.9	26.1
Hawaii	93	52.7	47.3
Idaho	36	63.9	36.1
Illinois	241	43.6	56.4
Indiana	354	57.6	42.4
Iowa	181	57.5	42.5
Kansas	84	31.0	69.0
Kentucky	159	56.6	43.4
Louisiana	159	39.6	60.4
Maine	87	43.7	56.3
Maryland	259	37.5	62.5
Massachusetts	109	47.7	52.3
Michigan	476	65.1	34.9
Minnesota	156	69.2	30.8
Mississippi	94	43.6	56.4
Missouri [3]	175	53.7	46.3
Montana	43	60.5	39.5
Nebraska	68	66.2	33.8
Nevada	10	20.0	80.0
New Hampshire	74	58.1	41.9
New Jersey	301	45.2	54.8
New Mexico	63	49.2	50.8
New York	296	69.6	30.4
North Carolina	78	53.8	46.2
North Dakota	11	90.9	9.1
Ohio	284	48.2	51.8
Oklahoma	47	42.6	57.4
Oregon	136	58.8	41.2
Pennsylvania	163	54.6	45.4
Puerto Rico	279	57.0	40.5
Rhode Island	59	72.9	27.1
South Carolina	259	53.3	46.7
South Dakota	16	68.8	31.3
Tennessee	124	31.5	68.5
Texas	99	37.4	62.6
Utah	64	48.4	51.6
Vermont	50	72.0	28.0
Virgin Islands	22	22.7	77.3

TABLE 11.—AGENCY AND CLIENT ERRORS, ERROR CASES AS A PERCENT OF TOTAL AFDC ERROR CASES, OCTOBER 1984–SEPTEMBER 1985 [1]—Continued

State	Total number of error cases	Percent of total error cases attributed to [2]—	
		Agency	Client
Virginia	120	51.7	48.3
Washington	234	59.8	40.6
West Virginia	154	35.1	64.9
Wisconsin	359	65.5	34.5
Wyoming	39	82.1	17.9

[1] Includes ineligible and eligible cases receiving incorrect payments.
[2] Percentages weighted by the proportion of each State's average caseload to the National average.
[3] Data incomplete.

Source: Office of Family Assistance, Family Support Administration, January 1988.

APPENDIX L. DESCRIPTION OF OTHER MAJOR FEDERAL ASSISTANCE PROGRAMS NOT WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS

Several Federal programs outside of the jurisdiction of the Committee on Ways and Means provide benefits to some share of those people who also benefit from assistance programs that are within the jurisdiction of the committee. This appendix describes several such programs: food stamps; Medicaid; housing assistance; school lunch and breakfast programs; the supplemental food program for Women, Infants, and Children (WIC); assistance provided under the Job Training Partnership Act; Head Start; Low-Income Home Energy Assistance Program (LIHEAP); and Veterans' Benefits and Services Programs.

Most families receiving AFDC would have incomes low enough to qualify them—or particular members of those families—for assistance under these programs. Unlike the principal assistance programs under the jurisdiction of the Committee on Ways and Means, and Medicaid and food stamps, participation in these programs is limited either by appropriations, or, in the case of the school feeding programs, by the willingness of schools to participate. Income received from AFDC is counted in determining eligibility for these programs—as well as benefit levels, in some cases. However, because these programs provide in-kind rather than cash assistance, benefits received under these programs are not counted in determining eligibility for AFDC.

Tables 1 and 2 describe the overlap in recipients between programs within the jurisdiction of the Committee on Ways and Means and other major Federal assistance programs. Table 1 illustrates that 80.3 percent of AFDC recipient households also receive food stamps; 15.1 percent receive WIC; 95.2 percent receive Medicaid, 50.5 percent received free or reduced-price school meals; and 24.8 percent receive housing assistance of some form.

Table 2 illustrates the reverse. For example, 48.7 percent of food stamp households receive AFDC; 23.3 percent of food stamp households receive SSI; and 3.5 percent of food stamp households receive unemployment compensation benefits.

TABLE 1.—PERCENT OF RECIPIENTS IN PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS RECEIVING ASSISTANCE FROM OTHER MAJOR FEDERAL ASSISTANCE PROGRAMS

[Households, first quarter of 1986]

	AFDC	SSI	Social Security	Unemployment compensation	Medicare
Number of households receiving benefits (in thousands)	3,617	3,110	23,874	2,322	21,355
Percent receiving:					
Food stamps	80.3	44.7	6.5	8.9	6.4
WIC	15.1	2.7	0.5	2.3	0.2
Free or reduced-price school meals	50.5	14.7	3.9	13.0	2.1
Public or subsidized rental housing	24.8	20.7	6.4	4.1	7.0
Medicaid	95.2	100.0	11.1	8.9	11.8
VA compensation or pensions	1.7	5.2	8.1	2.5	7.7

Note: Table reads that 80.3 percent of AFDC households, also receive food stamps.

Source: U.S. Bureau of the Census, Survey of Income and Program Participation.

TABLE 2.—PERCENT OF RECIPIENTS IN OTHER MAJOR FEDERAL ASSISTANCE PROGRAMS RECEIVING ASSISTANCE UNDER PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS

[Households, first quarter of 1986]

	Food stamps	WIC	Free or reduced school meals	Public or subsidized rental housing	Medicaid	VA compensation or pensions
Number of households receiving benefits (in thousands)	5,965	1,274	5,804	3,577	7,524	3,154
Percent receiving:						
AFDC	48.7	42.9	31.5	25.1	45.7	2.0
SSI	23.3	6.7	7.9	18.0	41.3	5.1
Social Security	26.2	9.1	15.9	42.4	35.2	61.3
Unemployment compensation	3.5	4.2	5.2	2.7	2.7	1.8
Medicare	22.8	3.5	7.8	42.0	33.5	52.4

Note: Table reads that 48.7 percent of food stamp recipients receive AFDC.

Source: U.S. Bureau of the Census, Survey of Income and Program Participation.

FOOD STAMP PROGRAM

The food stamp program is designed to increase the food purchasing power of low-income households to a point where they can buy a nutritionally adequate low-cost diet. The theory behind the program is that a participating household is expected to be able to devote 30 percent of its countable[1] cash income to food, with food stamp benefits making up the difference between that amount and the sum determined to be sufficient to buy an adequate low-cost diet; i.e., the cost of the Department of Agriculture's "Thrifty Food Plan." Thus, an eligible household with no countable cash income receives the maximum monthly food stamp allotment for its size (benefits also vary by household size), while one with some countable cash income receives a lesser allotment—reduced from the maximum at the rate of 30 cents for each dollar of countable cash income. Food stamp benefits are available to nearly all households meeting the *income and liquid assets eligibility tests,* as long as certain household members fulfill employment-related requirements. Further, households composed entirely of Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) recipients are automatically eligible for food stamps, without regard to the food stamp income and assets tests.

ADMINISTRATION AND FUNDING

The food stamp program operates in all 50 States, the District of Columbia, the Virgin Islands and Guam.[2] Through June 1982, it also operated in Puerto Rico. However, in July 1982, the program was legislatively terminated and replaced by a nutrition assistance program designed by the Commonwealth and federally funded with an annual block grant; this program provides cash benefits somewhat smaller than food stamp benefits to about 1.4 million persons.[3] The Federal Government, under the authority of the Food Stamp Act of 1977, establishes the rules that govern the program and, with certain minimal variations for Alaska, Hawaii and the territories, they are nationally uniform. States may opt to offer the program or not; but, if a State chooses to offer it, it must offer the program throughout the State.[4]

At the Federal level, the program is administered by the U.S. Department of Agriculture's Food and Nutrition Service, which gives direction, through Federal regulations, to States and localities in their administrative tasks, is responsible for the printing and distribution of stamps to the States, and oversees participation by retail food stores and other food outlets. Other Federal involvement includes the Federal Reserve System, through which food stamps deposited in financial institutions by food outlets are redeemed and converted to cash, and the Treasury Department and the Social Security Administration, which provide some information used in verifying recipients' income and assets. At the State and local levels, it is administered, along with the AFDC program, by welfare departments, which are responsible for determining eligibility and issuing benefits.[5]

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[1] Not all of a household's income is actually counted when determining its food stamp benefits. In effect, this means that the program assumes households can spend about 20–25 percent of their *gross* cash income on food.

[2] The Commonwealth of the Northern Mariana Islands operates a specially designed variant of the food stamp program, with benefit and eligibility rules roughly comparable to those in the 48 States and the District of Columbia, though simplified and somewhat more restrictive. In addition, certain controls are placed on the use of food stamp benefits in order to encourage the production and purchase of local commodities.

[3] The Commonwealth of Puerto Rico's nutrition assistance program provides cash benefits to low-income residents using eligibility tests that are more restrictive than those of the food stamp program. Maximum benefit levels are about 25 percent lower than regular food stamp benefit amounts, although average benefits received are approximately the same as the U.S. average because participants' incomes are lower. For fiscal years 1987 through 1990, the nutrition assistance block grant is to be increased, in stages, from $852,750,000 in fiscal year 1987 to $936,750,000 in fiscal year 1990.

[4] States may not operate a program if sales taxes are charged on food stamp purchases.

TABLE 3.—RECENT FOOD STAMP EXPENDITURES

[In millions]

Fiscal year	Benefit expenditures (Federal)	Administrative costs		Total
		Federal [1]	State/local [2]	
1979	$6,480	$515	$388	$7,383
1980	8,685	503	375	9,563
1981	10,630	678	504	11,812
1982 [3]	10,408	709	557	11,674
1983 [4]	11,955	779	613	13,347
1984 [4]	11,496	974	808	13,278
1985 [5]	11,556	1,043	871	13,470
1986 [6]	11,416	1,113	912	13,441
1987 (estimated) [7]	11,344	1,196	994	13,534

[1] Includes all Federal administrative costs associated with the Food Stamp program, including Federal matching of State and local costs and those costs attributed to budget accounts other than the food stamp account.

[2] Estimated.

[3] Includes spending for Puerto Rico's nutrition assistance block grant, which began operation in the last quarter of fiscal year 1982: estimated at $200 million for benefits and $6.5 million each for Federal and Commonwealth administrative spending.

[4] Includes spending for Puerto Rico's nutrition assistance block grant: estimated at $800 million for benefits (including special agricultural projects) and $25 million each for Federal and Commonwealth administrative spending.

[5] Includes spending for Puerto Rico's nutrition assistance block grant: $803.5 million for benefits (including special agricultural projects) and $21.5 million each for Federal and Commonwealth administrative spending.

[6] Includes spending for Puerto Rico's nutrition assistance block grant: estimated at $800 million for benefits and $20 million each for Federal and Commonwealth administrative spending.

[7] Includes spending for Puerto Rico's nutrition assistance program: $827 million for benefits and $25 million each for Federal and Commonwealth administrative spending.

Note: Figures presented in this table have been revised, as compared to similar tables presented in earlier versions of this print, to reflect more recent spending information.

The Food Stamp Act provides for 100 percent Federal funding of food stamp benefits.[6] Federal funds also pay Federal administrative costs and 50 percent of most State and local administrative costs.[7] State and local costs associated with computerization and

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[5] With the Department of Agriculture's approval, Indian tribes may administer the food stamp program on reservations and Indian lands. In certain cases, social security district offices may provide intake services for applicants who are also supplemental security income (SSI) or social security recipients.

[6] In Puerto Rico, Federal funds pay for 100 percent of the benefit costs of its nutritional assistance program and 50 percent of any Commonwealth administrative costs—up to the amount of the annual block grant.

[7] As an incentive for improved administration, a State qualifies for a matching rate of 60 percent if it reduces its rate of erroneous payments and under issuances below 5 percent of benefits

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fraud control activities are eligible for 75 percent Federal funding. Administrative costs not borne by the Federal Government are shared by States and localities according to State law.

ELIGIBILITY

The food stamp program generally imposes three major tests for eligibility: monthly income limits; liquid assets limitations; and employment-related requirements. Households in which all members receive Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) are automatically ("categorically") eligible for food stamps, as long as they meet food stamp employment-related requirements and certain other food stamp rules.

The food stamp household

Generally, all individuals living together and purchasing food and preparing meals in common constitute a food stamp "household" and must apply together; the income and assets of all household members are aggregated in determining eligibility and benefits, and, when judging whether all household members receive cash welfare (AFDC or SSI) for automatic eligibility purposes, the food stamp household definition is used. However, individuals who live together may, in some cases, apply as separate "households" and have only their income and assets considered in determining their eligibility and benefits. The basic rule is that those who purchase food and prepare meals apart from the rest of their residential unit may apply separately. This rule is modified by: (1) a requirement that, except for elderly and disabled individuals,[8] and parents with minor children, relatives (i.e., parents, children, and siblings) must apply together without regard to the "purchase and prepare" rule; (2) a requirement that individuals living in treatment programs for drug addicts or alcoholics, certain small group homes for the disabled, shelters for battered women and children, and shelters for the homeless be treated as separate households without regard to the "purchase and prepare" rule; and (3) an exception providing that elderly individuals who cannot purchase food and prepare meals because of a substantial disability[9] may apply as separate households, as long as the remainder of their residential unit has gross monthly income below certain federally prescribed levels.

Income

In determining eligibility for most households, the Food Stamp program looks at a household's monthly income.[10] Further, it considers both gross and countable monthly income.

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issued and has very low rates of improper denials. In addition, a State may lose a portion or all of its Federal share of administrative expenses if it does not meet certain legislatively established targets for reducing its rate of erroneous payments to 5 percent.

[8] In the food stamp program, "elderly" is defined as age 60 or older. "Disabled" is defined as being in receipt of disability payments under social security or SSI programs, and includes certain severely disabled veterans and their disabled survivors, and some disability retirement annuitants.

[9] The definition of disability for this purpose is significantly more limited than the one generally used for food stamp purposes.

[10] At application, a household's current income is considered. However, for many households, their most recently reported prior month's income is used to set benefits during their period of

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Gross income includes all cash income of the household, except for: certain payments made to third parties (rather than directly to the household); small amounts of irregularly received income; loans; income received for the care of someone outside the household; income earned by schoolchildren; nonrecurring lump-sum payments such as income tax refunds (counted as assets); energy assistance; a portion of student aid; child support payments to AFDC recipients up to $50 a month (at State option and cost); and certain other income required to be disregarded by other Federal laws.

Countable income for households without an elderly or disabled member (see footnote 8) subtracts from gross income the following: (1) an inflation indexed standard deduction now standing at $102 per month, regardless of household size;[11] (2) 20 percent of any earned income, in recognition of taxes and work expenses; (3) any work or training-related expenses for the care of a dependent, up to a ceiling of $160 per houshold per month; and (4) any shelter expenses, to the extent they exceed 50 percent of the countable income remaining after all other potential deductions and excluded expenses have been subtracted out, but not in excess of an inflation indexed ceiling ($164 per household per month).[12]

Countable income for households having an elderly or disabled member (see footnote 8) subtracts from gross income the following: (1) an inflation indexed standard deduction now standing at $102 per month, regardless of household size (see footnote 11); (2) 20 percent of any earned income; (3) any work or training-relating expenses for the care of a dependent, up to a ceiling of $160 per household per month; (4) out-of-pocket medical expenses of elderly or disabled household members, to the extent they exceed $35 per month; and (5) any shelter expenses, to the extent they exceed 50 percent of the countable income remaining after all other potential deductions and excluded expenses have been subtracted out (with no limit).

TABLE 4.—FOOD STAMP DEDUCTION LEVELS

[Through September 1988]

	48 States and D.C.	Alaska	Hawaii	Virgin Islands	Guam
Monthly standard deduction	$102	$175	$144	$90	$205
Monthly ceiling on shelter expense deductions	164	285	234	121	199
Monthly ceiling on dependent care deductions	160	160	160	160	160

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eligibility. In some cases, annual income is converted to a monthly basis (e.g., where income for a whole year is actually received in a few months).

[11] Inflation indexing of the standand deduction occurs each October. Standard deduction amounts vary for Alaska, Hawaii, the Virgin Islands, and Guam; see table 4.

[12] Inflation indexing of this ceiling occurs each October. The ceiling varies for Alaska, Hawaii, the Virgin Islands, and Guam; see table 4.

In order to qualify for food stamps, all households must have countable monthly income (as calculated with regard to whether or not they have elderly or disabled members) below the Federal poverty levels (see table 5). These poverty levels are adjusted each October to reflect inflation as measured by the Consumer Price Index. In addition, households without an elderly or disabled member must have gross monthly income below 130 percent of the Federal poverty levels (see table 5), also adjusted for inflation each October.

The current limits on countable and gross income in the 48 contiguous States, the District of Columbia, the Virgin Islands, and Guam[13] are as follows, through September 1988:

TABLE 5.—COUNTABLE AND GROSS INCOME ELIGIBILITY LIMITS

[Through September 1988]

Household size	Countable income limits per month (Federal poverty level)	Gross income limits per month (130 percent of Federal poverty level)
1 person	$459	$596
2 persons	617	802
3 persons	775	1,008
4 persons	934	1,214
5 persons	1,092	1,420
6 persons	1,250	1,625
7 persons	1,409	1,831
8 persons	1,567	2,037
Each additional member	+159	+206

Assets

Eligible households not qualifying under automatic eligibility rules for AFDC and SSI recipients must also have liquid assets not exceeding $2,000, or $3,000 in the case of households with elderly members. This liquid assets limit excludes the value of a residence, a portion of the value of motor vehicles, business assets, household belongings, and certain other resources.

Employment-related requirements

In order to maintain eligibility, non-working, able-bodied adult household members must register for work, and accept suitable employment if offered. Exceptions are provided for: those caring for dependents (disabled or under age 6); those subject to another program's employment requirements; those working at least 30 hours a week (or earning the minimum-wage equivalent); the limited number of post-secondary students who are otherwise eligible; residents of drug addiction or alcoholic treatment programs; those under age 16 or age 60 or older; and those between 16 and 18 if they are not the head of a household or are attending school or a training program. A limited exception, from having to accept employment, is provided for those responsible for the care of a child between 6 and 12 for whom adequate child care is not available.

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[13] Limits are higher in Alaska and Hawaii, by 25 and 15 percent, respectively.

Work registrants, unless exempted as noted above, may also be required to fulfill employment-related requirements imposed by each State. These may include workfare obligations, job search requirements, or other employment-related or training requirements.

Failure to fulfill employment-related requirements disqualifies the entire household if the head of household fails to comply. In other cases, failure to comply disqualifies the violating household member.

Other limitations

Categorical eligibility restrictions include: (1) a ban on eligibility for households in which the primary wage-earner has voluntarily quit a job without good cause, for 90 days from the date of the voluntary quit; (2) a ban on eligibility for households containing striking members, unless eligible before the strike; (3) a ban on eligibility for most non-working post-secondary students without families; (4) a ban on eligibility for illegally or temporarily resident aliens and rules limiting eligibility for legally present aliens with sponsors; (5) a ban on eligibility for persons living in institutional settings, except for those in special small group homes for the disabled, persons living in drug addiction or alcoholic treatment programs, persons in temporary shelters for battered women and children, and shelters for the homeless; and (6) a ban on eligibility for SSI recipients in California and Wisconsin.[14]

Under these eligibility rules, it is estimated that over 30 million persons are eligible for food stamps, nationwide, at any point during the year.

BENEFITS

Food stamp benefits are a function of household size, countable monthly income, the cost of purchasing food using the Department of Agriculture's "Thrifty Food Plan," and, in some cases, geographical location. Maximum monthly allotments equal the cost of the Agriculture Department's Thrifty Food Plan, adjusted for household size and, in some instances, geographical location,[15] and indexed periodically for changes in food prices.[16] A participating household's actual monthly allotment is determined by subtracting, from the maximum for that household's size and location, an amount equal to 30 percent of its countable monthly income—on the assumption that it can afford to spend that much of its own income on food purchases, with the Food Stamp program supplementing its purchasing power to the extent necessary to buy an adequate low-cost diet. In determining benefits, the same countable income calculated when judging eligibility is used.

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[14] Cash SSI payments have been increased in these States to include an estimated value for food stamp benefits.

[15] Maximum allotments vary for Alaska, Hawaii, the Virgin Islands, and Guam, because of food costs that differ substantially from those in the 48 contiguous States and the District of Columbia.

[16] Indexed annually, each October, to reflect the change in food prices since the last adjustment.

Maximum monthly food stamp allotments, from which 30 percent of a household's monthly countable income is taken to determine a household's actual benefit, are as follows:

TABLE 6.—MAXIMUM MONTHLY FOOD STAMP ALLOTMENTS

[Through September 1988]

Household size	48 States and D.C.	Alaska [1]	Hawaii	Virgin Islands	Guam
1 person	$87	$113	$133	$111	$128
2 persons	159	207	244	205	235
3 persons	228	297	350	293	336
4 persons	290	378	444	373	427
5 persons	344	448	527	443	508
6 persons	413	538	633	531	609
7 persons	457	595	700	587	673
8 persons	522	680	800	671	770
Each additional person	+65	+85	+100	+84	+96

[1] These allotment levels are for urban Alaska. Benefit levels for rural Alaska are generally 30 to 50 percent higher to account for higher food prices in rural areas.

Households with no countable income receive the maximum monthly allotment for their household size, and households with some countable income receive the maximum allotment reduced by 30 percent of their countable, not gross, income. Monthly benefits are expected to average nearly $50 per person in fiscal year 1988.

Minimum monthly allotments vary by household size, type of income, and the extent to which deductions from gross income are claimed. In some cases, income eligibility limits are exceeded before the allotment value is reduced to zero. In these cases, minimum benefits most often range from $10 to $80 per month. In other cases, the benefit is reduced to zero before income eligibility limits are exceeded.

Food stamp benefits are issued monthly. The local welfare agency must either deny eligibility or make food stamps available within 30 days of application and must provide food stamps without interruption if an eligible household reapplies in a timely manner. Households in immediate need because of little or no income and very limited cash assets are required to be treated on an expedited (5-day service) basis. Benefits are issued in three ways: (1) the welfare office may issue the eligible household an "Authorization to Participate" (ATP) document which it then takes to a bank, post office, or other issuing point to pick up its food stamp allotment; (2) the household may be asked to come into the welfare office to pick up its food stamp allotment; or (3) the welfare agency may mail the household its monthly allotment. In some pilot areas, benefits may be issued in cash to elderly or disabled households, or in standardized amounts to other (e.g., AFDC) cash welfare recipients.

USE OF FOOD STAMPS

Typically, participating households use their allotment in grocery stores that have been approved to accept food stamps. To be approved, a store must demonstrate that 50 percent of its food sales are staple foods. In addition, wholesalers may be approved to accept food stamps from retailers in certain instances, and meal service programs of various types may be approved to accept food stamps for meals. Once they have accepted food stamps, retailers, wholesalers, and approved meal service programs deposit them in banks, where they convert immediately to cash and are eventually redeemed, through the Federal Reserve System, by the U.S. Treasury.

Food stamps are issued in booklets and in several denominations, the lowest of which is $1. When change is necessary, all change of $1 or more must be in food stamps; change of 99 cents or less is in cash.

INTERACTION WITH CASH ASSISTANCE PROGRAMS

The food stamp program in intertwined with cash assistance in two ways: it is administratively linked to cash welfare aid at the State and local levels, and its recipient population is made up largely of recipients of other government benefits.

At the State and local levels, the food stamp program for most recipients is administered by the same welfare offices and personnel that administer cash assistance, such as AFDC and General Assistance. This coadministration does not apply for most elderly or disabled persons whose cash assistance is administered through Social Security Administration offices. However, the Social Security Administration's district offices provide some intake services for the food stamp program to many SSI and Social Security recipients.

For most persons participating in the food stamp program, food stamp aid represents a second or third form of government payment (see table 7). Fewer than 20 percent of food stamp households rely solely on nongovernmental sources for their cash income, although over 30 percent have some income from these sources (earnings, private retirement income, alimony, dividends and interest). The AFDC program contributes to the income of about 40 percent of food stamp households, and for about 70 percent of these households AFDC is their only source of cash income. Some 20 percent of food stamp households receive Social Security or railroad retirement income, and almost one-third of them rely entirely on that income. SSI payments are made to nearly 20 percent of food stamp households, almost one-third of whom have no other cash income. State or local General Assistance is received by just over 10 percent of food stamp households, and unemployment insurance benefits go to 2 percent.

TABLE 7.—CHARACTERISTICS OF FOOD STAMP HOUSEHOLDS: 1976–85

[In percent]

Food stamp recipient households	Year and month survey was conducted								
	1976 (Sept.)	1978 (Feb.)	1979 (Nov.)	1980 (Aug.)	1981 (Aug.)	1982 (Aug.)	1983 (Feb.)	1984 (Aug.)	1985 (Summer)
With gross monthly income:									
Below the Federal poverty levels	82	87	82	87	90	95	93	93	94
Between the poverty levels and 125/130 percent of the poverty levels [1]	11	8	14	10	9	5	7	6	6
Above 125 percent/130 percent of the poverty levels [1]	7	5	4	2	1	*	*	1	*
With earnings	21	19	20	19	20	18	20	19	20
With public assistance income [2]	70	73	57	65	69	69	75	71	68
With AFDC income	43	43	34	NA	40	42	50	42	39
With SSI income	20	22	20	18	19	18	18	18	19
With children	57	NA	55	60	56	58	68	61	59
And nonelderly female heads of household	44	NA	40	NA	43	45	52	47	46
With elderly members [3]	17	17	24	23	21	20	18	22	21
With elderly female heads of household [3]	10	10	15	NA	14	14	12	16	16
Average household size	3.0	3.0	2.7	2.8	2.7	2.8	2.9	2.8	2.7

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[1] For 1976 and 1978, percentages shown indicate the proportions of households with incomes between the poverty levels and 125 percent of the poverty levels, and the proportions of households with incomes above 125 percent of the poverty levels. For later years, percentages shown indicate the proportions of households with incomes between the poverty levels and 130 percent of the poverty levels, and the proportions of households with incomes above 130 percent of the poverty levels.

[2] Public assistance income includes AFDC, SSI, and general assistance.

[3] For 1976 and 1978, elderly members and heads of household include those age 65 or older. For later years, elderly members and heads of household include those age 60 or older.

Source: U.S. Department of Agriculture (Food and Nutrition Service) surveys of the characteristics of food stamp households.

Compiled by the Congressional Research Service.

LEGISLATIVE ACTION: 1981-1982

The 97th Congress acted three times to hold down costs of the food stamp program and revise administrative rules: The Omnibus Budget Reconciliation Act of 1981; the Agriculture and Food Act of 1981; and the Omnibus Budget Reconciliation Act of 1982. The Congressional Budget Office (CBO) has estimated these actions held food stamp spending for fiscal year 1982 through fiscal year 1985 nearly $7 billion (or 13 percent) below what would have been spent under pre-1981 law: down $1.5 billion in fiscal year 1982; $1.3 billion in fiscal year 1983; $2 billion in fiscal year 1984; and $2.1 billion in fiscal year 1985.

In addition to numerous changes in administrative rules and actions aimed at reducing fraud and abuse, the cost-saving measures enacted in the 97th Congress consisted primarily of:

Delaying various inflation indexing adjustments that would have increased benefits (for example, no benefit indexing occurred in fiscal year 1982);

Reducing the maximum benefit guarantee to 99 percent (rather than 100 percent) of the cost of purchasing food in the Agriculture Department's Thrifty Food Plan, thereby slightly reducing potential benefits to all recipients (a loss of between $1 and $4 per household per month in the fiscal year 1983 inflation indexing of benefits, for example);

Reducing first-month benefits by prorating them according to the date when a household applies or reapplies;

Changing the rules governing how benefit calculations are rounded off;

Placing a gross income eligibility ceiling of 130 percent of the Federal poverty levels on all households except those with elderly or disabled members;

Replacing the food stamp program in Puerto Rico with an $825-million-a-year nutritional assistance block grant;

Reducing benefits slightly for those with earned income by counting more of their income;

Substantially eliminating eligibility for most strikers and postsecondary students;

Reducing benefits based on estimated household shelter expenses for some recipients;

Allowing States or localities to set up food stamp "workfare" programs;

Setting specific targets for States to meet in reducing the rate of erroneous benefit payments, with penalties for States that do not meet their targets; and

Requiring that many food stamp recipients report monthly on their income and other circumstances, and that States use a recent *prior* month's income in determining benefits rather than projecting benefits based on *current* income.

These actions did *not* cause a direct reduction in benefits for most food stamp households, although they delayed or lowered benefit increases scheduled under previous law. However, some 1 million persons did lose eligibility, and recipients are losing some benefits because of the implementation of rules governing treatment of shelter expenses and earnings, the monthly reporting/prior-month accounting system, certain new administrative rules, and limited funding for Puerto Rico block grant.

LEGISLATIVE ACTION: 1983–1984

The 98th Congress made few significant revisions to food stamp law in 1983 and 1984:

- —In Public Law 98–204, some of the Federal requirements for monthly reporting and retrospective budgeting (MRRB) in administering benefits for food stamp recipients were loosened and the Agriculture Department's authority to waive MRRB requirements was greatly increased;
- —In the Deficit Reduction Act of 1984 (Public Law 98–369), the ability of State welfare agencies to verify recipients' income and assets through the use of Internal Revenue Service information on unearned income was expanded, and recouping overissued benefits by "intercepting" Federal income tax refunds was permitted; and
- —In Public Law 98–473, an across-the-board 1-percent increase in the maximum allotment was enacted, effective November 1984.

LEGISLATIVE ACTION: 1985–1986

In 1985, the Food Security Act (Public Law 99–198) significantly liberalized food stamp benefit and eligibility rules, and added a requirement that all States implement employment-related requirements for food stamp recipients. The Act also extended the authorization for food stamp appropriations through fiscal year 1990, with annual dollar limits rising from $13 billion in 1986 to $16 billion in 1990. The provisions affecting programs under the Food Stamp Act (including Puerto Rico's nutritional assistance block grant) are expected to add between $500 million and $1.1 billion in new spending over the next 5 years.

Major *new initiatives* in the 1985 legislation included:

- —A requirement that States set up an employment and training program of their own design for employable food stamp recipients (including workfare, job search, and training as options);
- —Provisions encouraging States to computerize food stamp program operations;
- —A prohibition on the collection of sales taxes on food stamp purchases;
- —A requirement that households composed entirely of AFDC or SSI recipients be judged automatically eligible for food stamps;
- —A prohibition against banks charging fees to retailers for handling food stamps, as long as certain requirements are met;
- —An expansion of existing pilot project authority for States and localities to use simplified application and standardized benefit procedures for AFDC, SSI, and Medicaid recipients in the food stamp program;
- —Permission for States to disregard the first $50 a month of child support payments as income for food stamp purposes, if the State pays for food stamp benefit cost of doing so; and
- —A 6-month moratorium on collecting fiscal sanctions owed by States for high rates of erroneous payments, and a required study of the food stamp quality control system;

Provisions *increasing benefits* in the 1985 legislation included:

—An increase in the earned income deduction from 18 to 20 percent, thereby increasing benefits for those with earnings;

—Provisions significantly increasing the degree to which high shelter costs and dependent-care expenses are taken into account in determining benefits, thereby raising benefis for those with these expenses;

—Provisions expanding the definition of "disabled person" for food stamp purposes, thereby increasing benefits to some not previously classified as disabled by extending to them the special treatment given the elderly and disabled; and

—Increases in the nutritional assistance block grant to Puerto Rico over the next 5 years.

Eligibility liberalizations enacted included:

—Increases in the dollar limits on assets that can be held by eligible households;

—Exclusion of assets having liens against them;

—Liberalization of the treatment of assets of those who are self-employed;

—Liberalization of rules governing disqualification of persons failing to fulfill employment-related requirements; and

—Liberalization of certain rules dealing with disqualification of students in Job Training Partnership Act programs and those attending schools that do not require a high school diploma.

Benefit reduction provisions require:

—Counting earnings to on-the-job trainees under Job Training Partnership Act programs, except for dependents less than 19 years of age;

—Counting all but the tuition and mandatory fee components of education grants and loans, regardless of the form of the aid; and

—Counting the portion of cash welfare payments paid for living expenses without regard to the form of the payment (except for certain types of aid such as emergency or medical assistance).

In 1986, Congress amended the omnibus anti-drug abuse measure (enacted as P.L. 99-570) to allow homeless persons in shelters to participate in the program and to allow homeless persons to voluntarily use their food stamps for prepared meals served by shelters and soup kitchens.

Other 1986 legislation affecting food stamps included the Human Services Reauthorization Act (P.L. 99-425) and the Higher Education Act Amendments (P.L. 99-498). These acts liberalized the food stamp eligibility and benefit treatment of recipients of benefits under the Low-Income Home Energy Assistance Program (LIHEAP) and of student income from Federal education aid programs.

LEGISLATIVE ACTION: 1987

In 1987, four measures revising food stamp rules were enacted. The Stewart B. McKinney Homeless Assistance Act (P.L. 100-77) incorporated provisions expected to add net Federal costs of $54 million in fiscal year 1988 and nearly $70 million a year in later years. They included a small benefit increase for households with very high shelter costs, benefit increases for certain homeless households residing in "welfare hotels," authority for States to operate "outreach" programs to inform the homeless about food stamps (with 50-percent Federal cost-sharing), a benefit increase for parents with minor children living with relatives if the relatives purchase and prepare meals separately from the parents with minor children, a requirement that "expedited service" be provided to the homeless and those with extremely high shelter costs, and two cost-saving changes that delay the annual adjustment of food stamp income eligibility guidelines by 3 months and increase the penalty assessed those who fraudulently fail to report earnings. A second law, the Older Americans Act Amendments (P.L. 100-175) required the food stamp program to disregard income received by participants in employment programs for the elderly (so-called "title V" programs), and authorized grants to States to conduct outreach efforts to inform the elderly about food stamps, SSI, and Medicaid. The Charitable Assistance and Food Bank Support Act (P.L. 100-232) required the food stamp program to disregard income received as cash donations from private nonprofit charitable organizations (up to $300 a quarter). And, at the end of 1987, the Omnibus Budget Reconciliation Act (P.L. 100-203) authorized a special demonstration project for Washington State under which the State may test alternatives to the current welfare system, such as combining various welfare benefits and "cashing out" food stamps.

TABLE 8.—HISTORICAL FOOD STAMP STATISTICS

Fiscal year	Total Federal spending (in millions)[1]		Average monthly participation (in millions of persons)	Average monthly benefits (per person)		4-person maximum monthly allotment[2]
	Current dollars	Constant (1987) dollars[3]		Current dollars	Constant (1987) dollars[3]	
1972[4]	$1,867	$5,099	11.1	$13.50	$36.90	$108
1973	2,207	5,794	12.2	14.60	38.30	112
1974	2,838	6,839	12.9	17.60	42.40	116
1975[5]	4,619	10,023	17.1	21.40	46.40	150
1976	5,685	11,519	18.5	23.90	48.40	162
Transition quarter[6]	1,365	2,674	17.3	24.40	47.80	166
1977	5,461	10,291	17.1	24.70	46.60	166
1978	5,564	9,794	16.0	26.80	47.20	170
1979[7]	6,995	11,160	17.7	30.60	48.80	182
1980	9,188	12,907	21.1	34.40	48.30	204
1981	11,308	14,301	22.4	39.50	50.00	209
1982	[8] 11,117	13,089	[9] 21.7	[10] 39.20	46.20	[10] 233
1983	[8] 12,734	14,485	[9] 23.2	[10] 43.00	48.90	[10] 253
1984	[8] 12,470	13,629	[9] 22.4	[10] 42.70	46.70	[10] 253
1985	[8] 12,599	13,279	[9] 21.4	[10] 45.00	47.40	[10] 264
1986	[8] 12,529	12,888	[9] 20.9	[10] 45.50	46.80	[10] 268
1987 (est.)	[8] 12,540	[8] 12,540	[9] 20.5	[10] 45.80	[10] 45.80	[10] 271

[1] Federal costs, obligations including spending for benefits and administration.

[2] At the beginning of the fiscal year.

[3] Constant dollar adjustments made using the overall Consumer Price Index for All Urban Consumers (CPI-U).

[4] The first fiscal year in which benefit and eligibility rules were, by law, nationally uniform and indexed for inflation.

[5] The first fiscal year in which food stamps were available nationwide.

[6] July through September 1976.

[7] The fiscal year in which the food stamp purchase requirement as eliminated, promoting increased participation among eligible households.

[8] Includes funding for Puerto Rico's nutrition assistance block grant.

[9] Includes persons receiving aid under Puerto Rico's nutrition assistance program.

[10] Does not reflect lower benefits in Puerto Rico.

Notes: Allotment levels were indexed for inflation annually through calendar 1973, and semi-annually from January 1974 through calendar 1980. Since 1980, allotment levels have been increased in January 1981, October 1982, October 1983, October 1984, November 1984, October 1985, October 1986, and October 1987 ($290).

Figures presented in this table have been revised from similar tables presented in earlier versions of this print to reflect more recent spending information.

Compiled by the Congressional Research Service.

MEDICAID

Medicaid, authorized under title XIX of the Social Security Act, is a Federal-State matching entitlement program providing medical assistance for low-income persons who are aged, blind, disabled, members of families with dependent children and certain other pregnant women and children. Within Federal guidelines, each State designs and administers its own program. Thus there is substantial variation among the States in terms of persons covered, types and scope of benefits offered, and amounts of payments for services.

Medicaid eligibility is linked to eligibility under programs within the jurisdiction of the Committee on Ways and Means, namely AFDC and SSI. Further, some poor aged persons are covered under both the Medicare and Medicaid programs.

ELIGIBILITY

Generally, eligibility for Medicaid is linked to actual or potential receipt of cash assistance under the federally assisted Aid to Families with Dependent Children (AFDC) program and the Federal Supplemental Security Income (SSI) program.

While a connection to cash assistance is still the primary way to establish Medicaid eligibility, recent legislation has expanded the population groups eligible for program coverage. States are now required to cover all pregnant women meeting the States' income and resources requirements, whether or not they are receiving cash assistance. They are also required to phase-in coverage of all children under age 7 who meet such income and resources standards. Further, States have been given the option of extending their programs to cover additional low-income target groups.

There are two broad classes of eligibility under Medicaid: categorically needy and medically needy. All States are required to cover certain categorically needy persons (mandatory categorically needy) and may extend categorically needy coverage to certain additional persons (optional categorically needy). Coverage of the medically needy is optional with the States.

A. CATEGORICALLY NEEDY

All States[17] cover the "categorically needy" under their Medicaid programs. Generally, these are AFDC and SSI recipients, though States are given certain options with respect to coverage of the SSI population.

1. Coverage of families and children

A State is required to cover under Medicaid all persons receiving cash payments under its AFDC program. States are also required to extend categorically needy coverage to additional groups though they are not actually receiving a cash payment. Coverage must be extended for the following groups for an unlimited period, provided the individuals continue to meet the requisite criteria: persons whose cash payment would be less than $10; persons whose AFDC payments are reduced to zero because of recovery of overpayment of AFDC funds; certain work supplementation participants; certain children for whom adoption assistance agreements are in effect or foster care payments are being made under title IV-E of the Social Security Act; individuals ineligible for AFDC because of a requirement prohibited under Medicaid; and individuals eligible for Medicaid except for the 1972 Social Security increase.

States are also required to extend Medicaid coverage to additional groups of persons for specified time periods. Coverage must be extended for 4 months to certain families whose cash assistance has been terminated; this extension applies to families who received AFDC for at least 3 of the preceding 6 months and who lost coverage due to increased income from or hours of employment. Coverage must be extended for 4 months to certain families who, between August 16, 1984, and September 30, 1988, lose AFDC because of receiving child or spousal support payments. This extension applies to families who were receiving AFDC for at least 3 of the preceding 6 months. States must also extend coverage for 9 months to families losing AFDC because they no longer qualify for the 4-month disregard of $30 plus one-third of their monthly earned income; States have the option of extending this coverage for an additional 6 months to families who would be eligible for AFDC if the disregard were applied.

The law requires States to provide Medicaid coverage for certain additional pregnant women and children. They are required to cover under Medicaid all pregnant women, meeting AFDC income and resources requirements, from the medical verification of pregnancy. A woman who was eligible for and received Medicaid while pregnant remains eligible for all pregnancy-related and postpartum services under the plan through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

States are also required to phase-in Medicaid coverage for all young children who meet the income and resources requirements of the State's AFDC plan. A State is required to extend Medicaid coverage to all such children under age 7 born after September 30,

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[17] Arizona does not operate a traditional Medicaid program. Beginning October 1, 1982, it began implementation of a demonstration project under which a specified set of services are provided to the indigent, primarily on a prepaid basis.

1983. Coverage for these children is mandated under Medicaid though the child may not meet the definition of "dependent child" under AFDC. For example, the child may be in a two-parent family where the principal breadwinner is not unemployed.

States may elect to extend categorically needy coverage to certain additional groups of AFDC-related persons though these persons are not actually receiving a cash payment. For example, Medicaid may cover families with unemployed parents even though the State does not have an AFDC–UP program.

They may also cover all or reasonable categories of individuals under age 21 (or at State option, under age 20, or 19, or 18) who would be eligible for AFDC if they met the definition of dependent child. Reasonable categories include children in two-parent families, those who live in privately subsidized foster care, or those who live in certain institutional settings such as intermediate care facilities. (Note that States are required to cover such children under age 7 born after September 30, 1983.)

2. Coverage of the aged, blind, and disabled

Most States provide Medicaid coverage to all recipients of Federal SSI payments. However, States have the option of limiting Medicaid coverage of SSI recipients by requiring such persons to meet many more restrictive eligibility criteria that were in effect on January 1, 1972 (before implementation of SSI). The requirements may be more restrictive than SSI in defining blindness, disability, or income and resources; however, they may not be more restrictive than those in effect under the State's Medicaid plan in January 1972 or more liberal than applicable under SSI or the State's supplementary payment program. The following 14 States currently employ more restrictive criteria:

Connecticut
Hawaii
Illinois
Indiana
Minnesota
Missouri
Nebraska
New Hampshire
North Carolina
North Dakota
Ohio
Oklahoma
Utah
Virginia

States which elect to use more restrictive criteria must allow applicants to deduct medical expenses from income (not including SSI or optional SSP payments) in determining eligibility. This is sometimes referred to as a "spend down." For example, if an applicant has a monthly income of $400 (not including any SSI or SSP payments) and the State's income standard is $350, the applicant would be required to incur $50 in medical expenses (i.e., spend down) before he would be eligible for Medicaid.

States are also required to extend Medicaid coverage to additional groups of aged, blind, and disabled persons provided the individuals continue to meet the requisite criteria. A State must cover former SSI recipients who receive Social Security benefits, but lost their SSI payments following a Social Security cost-of-living increase (COLA), if they would still be eligible for SSI but for the COLA increase. A State must also cover certain disabled widows and widowers receiving increases under the 1983 amendments or who lose SSI upon entitlement at age 60 to early widow's or widower's Social Security benefits; individuals receiving mandatory State supplements; certain disabled adult children; and persons eligible for Medicaid in 1973 as long as they continue to meet the 1973 criteria.

Further, the law requires coverage of "qualified severely impaired" individuals. The definition of such individuals is virtually identical to that under section 1619(b) of the act. Specifically, these are persons who in the month preceding application of the provision were eligible for Medicaid and received SSI, SSP, or special SSI payments under 1619(a). Further, the Secretary must determine for these persons that: they continue to be blind or continue to have a disabling physical or mental impairment; except for earnings, they continue to meet all nondisability related requirements for SSI eligibility; they do not have enough unearned income to make them ineligible for SSI payments; the lack of Medicaid eligibility would seriously inhibit ability to continue or obtain employment; and they do not have earnings that are reasonably equivalent to the benefits (SSI, SSP if provided, Medicaid, and publicly funded attendant care services) that would be available in the absence of earnings.

States may provide Medicaid coverage to additional groups of persons including recipients of State-only supplementary cash payments; certain institutionalized individuals whose income, before deductions, does not exceed a special income level (which may not exceed 300 percent of the SSI benefit amount payable to an individual in his own home with no other resources); and certain noninstitutionalized disabled children who would be eligible if they were in an institution.

B. MEDICALLY NEEDY

States may also cover the medically needy under their Medicaid programs. These are persons: (1) who, except for income and resources, fall into one of the categories covered by the State (i.e., aged, blind, disabled, families with dependent children, pregnant women, and children); and (2) whose income and/or resources are in excess of the standards for categorically needy coverage. A State having a medically needy program must, at a minimum, provide coverage to children who would be eligible as mandatory categorically needy, and to pregnant women who would be eligible as either mandatory or optional categorically needy except for their incomes and resources. As a minimum, the State is required to offer ambulatory services to these children and prenatal and delivery services to the pregnant women. However, most States which offer medically needy programs also cover additional categories of persons.

States having medically needy programs establish income and resources standards. They must be based on family size, uniform for all individuals in a covered group, and reasonable. Further, for purposes of Federal matching payments, the income standard cannot exceed 133⅓ percent of the maximum payment for similarly sized families under the State's AFDC program.

Many persons who become medically needy do so only after they have reduced their incomes and/or resources to the requisite level. The process by which individuals reduce their income to the standard is known as the "spend down." For example, if an applicant has a monthly income of $400 and the State's income standard is $350, the applicant would be required to incur $50 in medical expenses (i.e., spend down) before he would be eligible for Medicaid.

The following States and jurisdictions provide medically needy coverage:

Arkansas
California
Connecticut
Washington, D.C.
Florida (to be terminated 10/88)
Georgia (limited program)
Hawaii
Illinois
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Montana
Nebraska
New Hampshire
New Jersey
New York
North Carolina
North Dakota
Northern Mariana Islands
Oklahoma
Oregon
Pennsylvania
Puerto Rico
Rhode Island
Tennessee
Texas (limited program)
Utah
Vermont
Virgin Islands
Virginia
Washington
West Virginia
Wisconsin

C. NEW OPTIONAL COVERAGE GROUPS

The Omnibus Budget Reconciliation Act of 1986 (OBRA86) permitted States to extend categorically needy Medicaid coverage to certain groups of individuals not previously eligible for such coverage. The first group is composed of pregnant women and children; the second group is composed of the aged and disabled. The Omnibus Budget Reconciliation Act of 1987 (OBRA87) further expanded States options with respect to coverage of low-income pregnant women and children. See table 18 on status of implementation of this option.

The first optional categorically needy coverage group is composed of pregnant women, infants up to age 1, and on an incremental basis, children up to age 5 with incomes below a State-established level not exceeding 100 percent of the Federal poverty line. The provision was effective April 1, 1987, for pregnant women and infants. Beginning in fiscal year 1988, States could increase the age level by one in each fiscal year until all children under age 5 were included. States could not elect to cover one age group until all younger age groups were covered.

OBRA87 included provisions which allow States to expand the scope of coverage under this provision. It permits States to accelerate coverage of children under age 5 whose income is below the poverty line. Effective July 1, 1988, States can cover children under age 2, 3, 4, or 5 (as selected by the State) who are born after September 30, 1983. Effective October 1, 1988, States can expand coverage to children under age 8 born after September 30, 1983. States would thus be able to cover all such children by fiscal year 1991.

OBRA87 also permits States, effective July 1, 1988, to increase the State-established income level for pregnant women and infants to 185 percent of the Federal poverty line. States could impose a premium for such coverage. The amount of the premium could not exceed 10 percent of the amount by which the family's income (less childcare expenses) exceeded 150 percent of the Federal poverty line for a comparable sized family.

Imposition of resource standards for the new coverage category is optional with the States. If one is established, it may not be more restrictive in the case of pregnant women than that under SSI. For infants and children, States are not able to apply a resource standard that is more restrictive than the AFDC standard. Newly eligible pregnant women are only eligible for services related to pregnancy. For infants and children, coverage is identical to that offered other categorically needy recipients.

States which chose to cover this new population group prior to December 22, 1987, are prohibited from lowering their AFDC standard as in effect on April 17, 1986. States making elections subsequent to that date are prohibited from lowering their AFDC standard as in effect on July 1, 1987.

OBRA86 created a second optional categorically needy coverage group composed of the aged and disabled with family incomes up to a State-established level that does not exceed 100 percent of the Federal poverty line. The provision was effective July 1, 1987. A State electing this option would be required to cover some newly eligible pregnant women and infants.

States are required to apply the SSI resource standards, or the higher standards applicable under its medically needy program to this population group. A State choosing this option is required to offer the benefit package available to other categorically needy recipients. Alternatively, the State may elect to cover just the Medicare cost-sharing charges for this population group. The cost-sharing charges are: part A premiums, deductibles and coinsurance, and part B premiums, deductibles, and coinsurance. At State option, a State may also cover premiums for enrollment of beneficiaries in Medicare-qualified HMOs.

As of January 1, 1988, 26 States had elected to extend coverage to newly eligible pregnant women and children. As of August 1987, three States had elected to extend coverage to newly eligible aged and disabled persons.

MEDICARE-MEDICAID RELATIONSHIP

An estimated 2.4 million aged and disabled Medicare enrollees are also covered by State Medicaid programs. While coverage under Medicare part A (hospital insurance) is automatic for most aged and certain disabled having insured status under the Social Security system, coverage under Medicare part B (supplementary medical insurance) requires the payment of a monthly premium. Most States make this payment for their Medicaid eligibles under a buy-in agreement. While States may buy-in to Medicare for both their cash-assistance and medically needy populations who are eligible for Medicare, Federal matching for premium payments is only available for the cash assistance group. If a State does not buy-in to part B coverage, it cannot receive Federal matching payments for services that would have been covered under Medicare if there had been a buy-in arrangement. One State and two jurisdictions do not currently have a buy-in arrangement. These are: Wyoming, Puerto Rico, and Northern Mariana Islands.

Medicaid basically supplements Medicare for persons who are dually eligible. Medicare makes the primary payment while State Medicaid expenditures are limited to payments for deductibles, coinsurance, and services not covered by Medicare.

SERVICES

States are required to offer the following services to categorically needy recipients under their Medicaid programs: inpatient and outpatient hospital services; laboratory and X-ray services; skilled nursing facility (SNF) services for those over age 21; home health services for those entitled to SNF care; early and periodic screening, diagnosis, and treatment (EPSDT) for those under age 21; family planning services and supplies; physicians' services, and nurse-midwife services. They may also provide additional medical services such as drugs, intermediate care facility (ICF) services, eyeglasses, inpatient psychiatric care for individuals under age 21 or over 65 (see tables 17A and 17B). States are permitted to establish limitations on the amount of care provided under a service category (such as limiting the number of days of covered hospital care or number of physicians' visits).

Federal law establishes the following requirements for coverage of the medically needy: (1) if a State provides medically needy coverage to any group it must provide ambulatory services to children and prenatal and delivery services for pregnant women; (2) if a State provides institutional services for any medically needy group it must also provide ambulatory services for this population group; and (3) if the State provides medically needy coverage for persons in intermediate care facilities for the mentally retarded (ICF/MRs) or institutions for mental diseases, it must offer to all groups covered in its medically needy program the same mix of institutional and noninstitutional services as required under prior law (that is, either all of the mandatory services or alternatively the care and services listed in 7 of the 20 paragraphs in the law defining covered services).

FINANCING

The Federal Government helps States share in the cost of Medicaid services by means of a variable matching formula which is adjusted annually. The matching rate, which is inversely related to a State's per capita income, can range from 50 percent to 83 percent though currently the highest rate is 79.65 percent. Federal matching for the territories is set at 50 percent with a maximum dollar limit placed on the amount each territory can receive. The Federal share of administrative costs is 50 percent for all States except for certain items where the authorized rate is higher.

REIMBURSEMENT POLICY

States have considerable leeway in setting reimbursement levels for services. They are required to reimburse hospitals, skilled nursing facilities, and intermediate care facilities at rates that are reasonable and adequate to meet the cost which must be incurred by efficiently and economically operated facilities in order to meet applicable laws and quality and safety standards. In developing their payment rates for hospitals, States are required to take into account the situation of facilities which serve a disproportionate number of low-income patients. Further, hospital payment rates must be sufficient to assure that Medicaid patients have reasonable access to services of adequate quality.

Practitioners and providers are required to accept payments under the program as payment in full for covered services except where nominal cost-sharing charges may be required. States may generally impose such charges with certain exceptions. They are precluded from imposing such charges on services for children under 18, services related to pregnancy, family planning or emergency services, HMO services for the categorically needy, and services provided to SNF or ICF inpatients who are required to spend all of their income for medical care except for a personal needs allowance.

ADMINISTRATION

Medicaid is a State-administered program. At the Federal level, the Health Care Financing Administration (HCFA) of the Department of Health and Human Services is responsible for overseeing State operations.

Federal law requires that a single State agency be charged with administration of the Medicaid program. Generally, that agency is either the State welfare agency, the State health agency, or the umbrella human resources agency. The single State agency may contract with other State entities to conduct some program functions. Further, States may process claims for reimbursement themselves or contract with fiscal agents or health insuring agencies to process these claims.

RECENT LEGISLATIVE CHANGES

The following is a summary of the major Medicaid changes enacted as part of the Omnibus Budget Reconciliation Act of 1986 (OBRA86), Public Law 99-509:

1. *Optional coverage of pregnant women and infants.*—The law created a new optional categorically needy group composed of pregnant women, infants up to age 1, and on an incremental basis, children up to age 5 with family incomes below a State-established level. States could choose an income level between the AFDC level and 100 percent of the Federal poverty line. Imposition of resource standards is optional with the States. The provision was effective April 1, 1987, for pregnant women and infants. Beginning in fiscal year 1988, States could increase the age level by one in each fiscal year until all children up to age 5 were included. States could not elect to cover one age group unless children in all younger groups were covered.

2. *Optional coverage of elderly and disabled poor.*—The law created a new optional categorically needy coverage group composed of the aged and disabled with family incomes up to a State-established level that does not exceed 100 percent of the Federal poverty line. A State choosing this option would have to offer the benefit package available to other categorically needy recipients. As an alternative, States could cover just the Medicare cost-sharing expenses for this population group. A State electing expanded coverage of the aged and disabled would be required to cover some

newly eligible pregnant women and infants as described in item 1. The optional coverage is effective July 1, 1987.

3. *Medicaid eligibility for qualified severely impaired individuals.*—The law required States to continue Medicaid coverage for disabled persons with severe impairments who have lost their eligibility for cash assistance because of their earnings from work. A qualified severely impaired individual is one: who is under age 65; who in the month preceding the first month this provision applies received cash assistance benefits or special benefits under section 1619 of the Social Security Act; and who received Medicaid benefits. Further such individual: (a) must continue to be blind or have a disabling physical and mental impairment; (b) must meet, except for earnings, all other requirements for SSI eligibility; (c) would be seriously inhibited from continuing work in the absence of Medicaid coverage; and (d) does not have earnings that would be sufficient to provide a reasonable equivalent of the Medicaid, SSI, or publicly funded attendant care benefits that would be available if he did not work. (Public Law 99-643, the SSI Improvements Amendments of 1986, revised and extended on a permanent basis the authority contained in section 1619 of the Social Security Act.)

4. *Homeless.*—The law clarifies that States or localities are prohibited from imposing any residence requirement which excludes from Medicaid any otherwise qualified individual who resides in the State, regardless of whether the residence is maintained permanently or at a fixed address.

5. *Payments for aliens.*—The law specifies that Federal matching payments are not available for State expenditures for aliens who are not lawfully admitted for permanent residence or permanently residing in the United States under color of law. An exception is made where the individual is otherwise eligible for Medicaid and has an emergency medical condition. [IRCA (P.L. 99-603) authorized full MA for certain otherwise eligible aliens receiving amnesty (children under 18, Cubans and Haitians, aged, blind, and disabled recipients of SSI.]

6. *Presumption of eligibility for pregnant women.*—The law permits States to make ambulatory prenatal care available to pregnant women for a presumptive period of eligibility. A presumptive period of eligibility is defined as beginning on the date on which a qualified provider determines on the basis of preliminary information that the family income falls below the applicable Medicaid standard. The period ends on the earlier of: (a) the day on which a determination is made on the application by the state agency; (b) 45 days after the provider makes the determination; or (c) 14 days after the preliminary determination if the woman does not file an application.

7. *Respirator care for ventilator-dependent individuals.*—The law permits states to cover respiratory care services in the home for individuals who are: (a) medically dependent on a ventilator for life support at least 6 hours a day; (b) who have been so dependent at least 30 days as inpatients; (c) have adequate social support services at home; (d) who wish to be cared for at home; and (e) who in the absence of such care, would require respiratory care on an inpatient basis for which Medicaid would pay. Respiratory care services are defined as those services, not otherwise included within

covered services under a State's Medicaid plan, provided on a part-time basis in the home of an individual by a respiratory therapist or other person skilled in respiratory therapy.

8. *Permitting States to offer home and community-based services to low-income individuals at risk of hospital care.*—The law allows States, subject to approval of the Secretary, to provide services under a home and community-based services waiver to individuals who, but for the provision of such services, would otherwise require the level of care provided in a hosptial, SNF, or ICF and such services would be paid for by Medicaid. States would be permitted to target their waivers to individuals at risk of hospital care, as defined by illness or diagnosis (e.g., AIDS, or AIDS-related condition) or by condition (e.g., chronic mental illness, ventilator dependency).

9. *Hold harmless.*—COBRA provided that beginning in fiscal year 1987, the Federal Medical Assistance Percentage (FMAP) would be calculated on an annual rather than a biennial basis. The bill would provide that the change to the annual calculation would not apply to State Medicaid programs in fiscal year 1987 only, if the State would be adversely affected by the change.

10. *Independent quality review of Health Maintenance Organizations (HMOs).*—The law requires States to provide for an annual independent external review of the quality of services provided or arranged by each HMO or other prepaid plan with which the State has entered a risk-based contract.

11. *State utilization review systems.*—The law prohibits the Secretary from issuing regulations requiring States to operate second surgical opinon programs for inpatient hospital preadmission review programs under their Medicaid plans. The prohibition is in effect until 180 days after submission of a report to Congress on the experience under existing second opinion programs.

12. *Prohibition of certain physician incentive plans.*—The law provides for a civil money penalty of $2,000 per patient if a hospital or an entity delivering services on a risk basis (including HMOs) knowingly makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit services to Medicaid patients who are under the direct care of the physician. A physician who accepted such a payment could be liable for a civil money penalty of $2,000 per patient. The Secretary is required to report to the Congress by January 1, 1988, on the incentive arrangements offered by HMOs and competitive medical plans. The provision is effective 6 months after enactment for hospitals and April 1, 1989, for HMOs and other entities contracting on a risk basis.

The following is a summary of the major Medicaid changes enacted as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA87), Public Law 100-203:

1. *Optional coverage of pregnant women and infants.*—OBRA87 allows States to expand the scope of coverage authorized under OBRA86 for pregnant women and children. It permits States to accelerate coverage of children under age 5 whose income is below the poverty line. Effective July 1, 1988, States can cover children under age 2, 3, 4 or 5 (as selected by the State) who are born after September 30, 1983. States would thus be able to cover all such children by Fiscal Year 1991.

The law also permits States, effective July 1, 1988, to increase the State-established income level for pregnant women and infants to 185 percent of the Federal poverty line. States could impose a premium for such coverage. The amount of the premium could not exceed 10 percent of the amount by which the family's income (less childcare expenses) exceeded 150 percent of the Federal poverty line for a comparable sized family.

2. *Coverage of children up to age 7.*—States are required to extend Medicaid coverage to all children under age 7, born after September 30, 1983, who meet the income and resources requirements of the State's AFDC plan. (Previously the mandated coverage provision extended to children under age 5 born after September 30, 1983.) Covergae for these children is mandated under Medicaid though the child may not meet the definition of "dependent child" under AFDC.

3. *Home and community-based services for the elderly.*—The law establishes a new waiver authority, separate from the existing "2176 waiver authority", to allow States on a budget-neutral basis, to provide home and community-based services for the elderly at risk of nursing home care. The budget neutrality formula limits States electing the waiver to a maximum rate of growth in institutional and noninstitutional long-term care services to 7 percent, compounded annually.

4. *Coverage of clinic services for the homeless.*—States, at their option may pay for services furnished by clinic personnel to eligible homeless individuals at locations outside the clinic.

5. *Payments to commonwealths and territories.*—The payment ceilings for the commonwealths and territories are increased by a total of $10.8 million in Fiscal Year 1988, $14.0 million in Fiscal Year 1989, and $15.4 million in Fiscal Year 1990.

6. *Payments to disproportionate share hospitals.*—The law implements the existing requirement that States take into account the situation of hospitals serving a disproportionate share of low-income patients with special needs. It requires each State, by July 1, 1988, to submit a plan amendment that defines disproportionate share hospitals and provides for an appropriate increase in the rate of payment for services provided by such hospitals. The payment adjustments are to be progressively phased in; full compliance is to be achieved in fiscal year 1990.

7. *State demonstration projects.*—The law extends the Arizona demonstration project through September 30, 1989. Further it authorizes the Secretary to grant specified Medicaid waivers to New York to implement its Prenatal/Maternity/Newborn Care pilot program and to Washington State for its Family Independence program.

8. *Nursing home quality improvements.*—The law revises the existing participation requirements, survey and certification procedures, and enforcement remedies for SNFs and ICFs under Medicaid.

PROGRAM DATA

Federal Medicaid outlays are estimated (in the absence of legislative changes) at $30.7 billion in fiscal year 1988, a 11.8 percent increase over the $27.4 billion estimated for fiscal year 1987.

In examining tables 9–18, it should be noted that detailed information of each State program is available in the Health Care Financing Administration publication, "Analysis of State Medicaid Program Characteristics, 1986."

Source: HCFA, Office of the Actuary, Division of Medicaid Cost Estimates, Medicaid Statistics Branch.

TABLE 9.—HISTORY OF MEDICAID PROGRAM COSTS

Fiscal year	Total		Federal		State	
	Dollars (in millions)	Percent increase	Dollars (in millions)	Percent increase	Dollars (in millions)	Percent increase
1966 [1]	$1,658		$789		$869	
1967 [1]	2,368	42.9	1,209	53.2	1,159	33.5
1968 [1]	3,659	55.6	1,837	51.9	1,849	59.5
1969 [1]	4,166	13.0	2,276	23.9	1,890	2.2
1970 [1]	4,852	16.5	2,617	15.0	2,235	18.3
1971	6,176	27.3	3,374	28.9	2,802	25.3
1972 [2]	8,434	36.6	4,361	29.2	4,074	45.4
1973	9,111	8.0	4,998	14.6	4,113	1.0
1974	10,229	12.3	5,833	16.7	4,396	6.9
1975	12,637	23.5	7,060	21.0	5,578	26.9
1976	14,644	15.9	8,312	17.7	6,332	13.5
TQ [3]	4,106	NA	2,354	NA	1,752	NA
1977	17,103	[4] 16.8	9,713	[4] 16.9	7,389	[4] 16.7
1978	18,949	10.8	10,680	10.0	8,269	11.9
1979	21,755	14.8	12,267	14.9	9,489	14.8
1980	25,781	18.5	14,550	18.6	11,231	18.4

TABLE 9.—HISTORY OF MEDICAID PROGRAM COSTS—Continued

Fiscal year	Total		Federal		State	
	Dollars (in millions)	Percent increase	Dollars (in millions)	Percent increase	Dollars (in millions)	Percent increase
1981	30,377	17.8	17,074	17.3	13,303	18.4
1982	32,446	6.8	17,514	2.6	14,931	12.2
1983	34,956	7.7	18,985	8.4	15,971	7.0
1984	37,631	7.7	20,094	5.8	17,537	9.8
1985[5]	40,917	8.7	[6] 22,655	12.7	[6] 18,262	4.1
1986	44,851	9.6	24,995	10.3	19,856	8.7
1987	49,344	10.0	27,435	9.8	21,909	10.3
1988 (current law estimate)	55,151	11.8	30,664	11.8	24,487	11.8
1989 (current law estimate)	58,872	6.7	32,733	6.7	26,139	6.7

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[1] Includes related programs which are not separately identified though for each successive year a larger portion of the total represents Medicaid expenditures. As of Jan. 1, 1970, Federal matching was only available under Medicaid.

[2] Intermediate care facilities (ICFs) transferred from the cash assistance programs to Medicaid effective January 1, 1972; data for prior periods do not include these costs.

[3] Transitional quarter (beginning of Federal fiscal year moved from July 1 to Oct. 1).

[4] Represents increase over fiscal year 1976, i.e., five calendar quarters.

[5] Includes transfer of function of State fraud control units to Medicaid from Office of Inspector General.

[6] Temporary reductions in Federal payments authorized for fiscal years 1982–84 were discontinued in fiscal year 1985.

Note: Totals may not add due to rounding.

Sources: "Budget of the U.S. Government" fiscal years 1969–89, and conversations with officials of Health Care Financing Administration.

TABLE 10.—UNDUPLICATED NUMBER OF MEDICAID RECIPIENTS BY ELIGIBILITY CATEGORY, FISCAL YEARS 1972–89

[Number in thousands]

Fiscal year	Total	Aged 65 or over	Blindness	Permanent and total disability	Dependent children under age 21	Adults in families with dependent children	Other [1]
Ending June:							
1972	17,606	3,318	108	1,625	7,841	3,137	1,576
1973	19,622	3,496	101	1,804	8,659	4,066	1,495
1974	21,462	3,732	135	2,222	9,478	4,392	1,502
1975	22,007	3,615	109	2,355	9,598	4,529	1,800
1976	22,815	3,612	97	2,572	9,924	4,774	1,836
Ending September:							
1977 [2]	22,831	3,636	92	2,710	9,651	4,785	1,959
1978	21,965	3,376	82	2,636	9,376	4,643	1,852
1979	21,520	3,364	79	2,674	9,106	4,570	1,727
1980 [3]	21,605	3,440	92	2,819	9,333	4,877	1,499
1981 [3]	21,980	3,367	86	2,993	9,581	5,187	1,364
1982 [3]	21,603	3,240	84	2,806	9,563	5,356	1,434
1983 [3]	21,554	3,371	77	2,844	9,535	5,592	1,129
1984 [3]	21,607	3,238	79	2,834	9,684	5,600	1,187
1985 [3]	21,814	3,061	80	2,937	9,757	5,518	1,214
1986 [3]	22,518	3,140	82	3,100	10,031	5,647	1,366
1987 (current law estimate) [3]	23,335	3,224	87	3,224	10,191	5,991	1,332
1988 (current law estimate) [3]	24,178	3,483	91	3,351	10,457	6,213	1,458
1989 (current law estimate) [3]	24,996	3,548	93	3,454	10,814	6,448	1,532

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[1] This category is composed predominantly of children not meeting the definition of "dependent" children, i.e., "Ribicoff children."

[2] Fiscal year 1977 began in October 1976 and was the first year of the new Federal fiscal cycle. Before 1977, the fiscal year began in July.

[3] Beginning in fiscal year 1980, recipients' categories do not add to the unduplicated total due to the small number of recipients that are in more than one category during the year.

Source: HCFA, Office of the Actuary, Office of Medicaid Estimates and Statistics, Division of Medicaid Statistics.

TABLE 11.—MEDICAID RECIPIENTS BY BASIS OF ELIGIBILITY, FISCAL YEAR 1986

State	Total [1]	Aged	Blind	Disabled	In families with dependent children		Other recipients [2]
					Children	Adults	
Alabama	316,411	82,221	1,718	71,966	116.029	56,142	3,539
Alaska	28,720	2,593	60	2,380	15,176	6,703	3,857
Arkansas	203,342	51,002	1,349	44,162	61,214	33,173	12,442
California	3,466,100	469,860	23,960	512,440	1,375,980	860,420	223,440
Colorado	149,030	30,189	192	20,900	68,286	31,250	6,860
Connecticut	216,643	35,563	193	23,730	94,288	49,519	13,350
Delaware	39,270	5,405	109	5,295	18,945	10,121	1,668
District of Columbia	98,020	9,729	59	14,815	45,365	24,279	3,773
Florida	587,615	115,023	2,913	113,173	236,711	111,949	7,846
Georgia	483,514	92,322	3,020	103,730	221,769	110,622	2,376
Hawaii	88,901	11,055	196	8,218	47,335	27,681	1,069
Idaho	40,291	6,087	40	6,532	18,436	8,530	666
Illinois	1,063,541	80,963	1,204	136,311	542,076	282,878	20,109
Indiana	297,755	44,154	1,074	43,889	144,763	76,947	12,049
Iowa	221,905	30,785	759	23,704	103,193	67,382	20,786
Kansas	131,046	45,787	225	17,477	69,060	35,266	5,697
Kentucky	414,859	54,127	2,048	72,255	191,145	115,361	12,581
Louisiana	446,423	92,164	1,812	69,698	193,940	88,278	531
Maine	125,076	20,833	265	19,951	61,838	36,546	0
Maryland	323,404	42,737	357	38,649	161,259	76,097	4,305

TABLE 11.—MEDICAID RECIPIENTS BY BASIS OF ELIGIBILITY, FISCAL YEAR 1986—Continued

State	Total [1]	Aged	Blind	Disabled	In families with dependent children		Other recipients [2]
					Children	Adults	
Massachusetts	528,931	103,427	7,571	76,779	188,496	115,584	37,074
Michigan	1,119,724	95,708	2,353	148,320	625,516	349,409	67,978
Minnesota	344,459	56,912	658	36,167	138,308	84,483	28,960
Mississippi	318,871	62,564	1,710	61,413	126,920	56,002	10,262
Missouri	359,942	64,036	1,294	54,050	152,861	84,978	2,723
Montana	52,211	6,658	95	7,467	21,733	15,009	1,249
Nebraska	102,051	15,627	183	10,727	42,449	25,146	7,919
Nevada	32,545	6,105	411	5,138	13,122	7,563	2,034
New Hampshire	35,350	8,393	295	5,384	9,864	11,402	12
New Jersey	581,211	66,124	1,175	75,830	295,179	149,895	15,809
New Mexico	91,846	12,253	461	17,854	41,104	17,932	2,242
New York	2,322,628	353,387	4,002	302,758	989,349	529,408	143,724
North Carolina	378,218	67,445	1,492	51,113	161,358	92,159	4,651
North Dakota	40,150	9,266	53	4,973	14,227	12,452	175
Ohio	1,078,851	94,679	1,631	112,564	574,811	295,088	78
Oklahoma	242,339	54,496	475	27,462	105,556	51,359	2,991
Oregon	162,524	18,214	958	18,585	75,216	44,295	5,256
Pennsylvania	1,099,321	123,664	1,546	139,751	602,751	269,994	70,958
Rhode Island	97,203	19,053	304	17,823	38,170	21,173	680
South Carolina	262,136	45,705	1,887	55,899	161,503	99,614	1,928
South Dakota	36,651	7,971	141	6,031	14,468	6,852	1,188
Tennessee	394,673	72,126	2,540	84,166	168,600	57,578	9,663

Texas	878,985	213,305	4,384	117,049	369,634	173,606	1,007
Utah	75,622	7,913	88	8,886	34,777	21,818	9,428
Vermont	50,012	7,454	90	7,273	21,384	12,831	980
Virginia	314,190	57,566	1,150	49,394	127,305	71,018	7,757
Washington	357,879	42,275	387	48,943	195,191	97,326	5,879
West Virginia	211,174	35,668	353	41,688	71,770	59,859	1,836
Wisconsin	409,401	85,243	1,323	78,182	252,606	154,765	10,064
Wyoming	21,009	2,877	57	1,560	8,316	8,161	38
Puerto Rico	1,761,833	0	919	76,622	593,648	537,070	553,593
Virgin Islands	13,857	1,152	3	571	7,673	3,622	836
U.S. total	20,741,973	3,138,713	80,620	3,022,504	9,429,352	5,105,903	811,487
All Jurisdictions	22,517,663	3,139,865	81,542	3,099,697	10,030,673	5,646,595	1,365,916

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[1] Total is unduplicated count of recipients. A small number of recipients are in more than one category during the year.

[2] This category is composed primarily of children not meeting the definition of dependent child, i.e. "Ribicoff Children".

Source: Table prepared by Congressional Research Service, Education and Public Welfare Division. Based on data obtained from HCFA forms 2082. HCFA, Division of Medicaid Statistics.

TABLE 12.—TOTAL AND PER CAPITA MEDICAID PAYMENTS FOR CATEGORICALLY NEEDY AND MEDICALLY NEEDY, PRELIMINARY ESTIMATES, FISCAL YEARS 1981 AND 1986

	1981			1986			Real percent change 1981–86 [1]
	Amount (in millions)	Percent	Per capita amount	Amount (in millions)	Percent	Per capita amount	
Categorically needy:							
Receiving cash payments	$14,534.2	53.4	$861	$21,039.1	51.3	$1,268	17.7
Aged	2,480.2	9.1	1,270	3,784.9	9.2	2,253	24.1
Blind	108.5	.4	1,527	188.1	0.5	2,633	40.9

Disabled	5,615.7	20.6	2,490	8,905.3	21.7	3,690	28.9
Children in AFDC families	3,002.2	11.0	361	4,180.2	10.2	511	13.2
Adult in AFDC families	3,327.6	12.2	769	3,980.5	9.7	916	−2.7
Not receiving cash payments	4,735.5	17.4	2,641	8,752.7	21.3	2,934	50.3
Aged	3,143.1	11.5	5,273	4,993.4	12.2	6,859	29.2
Blind	18.9	.1	2,785	44.8	0.1	7,361	92.7
Disabled	1,213.9	4.5	5,146	2,596.7	6.3	7,484	73.9
Children in AFDC families	152.9	.6	302	423.7	1.0	450	125.3
Adult in AFDC families	86.9	.3	298	297.9	0.7	499	178.7
Other title XIX	119.7	.4	734	396.2	1.0	1,043	169.1
Total, categorically needy	19,272.9	71.0	1,032	29,791.8	72.6	1,522	25.7
Medically needy:							
Aged	4,302.7	15.8	5,260	6,321.5	15.4	8,636	19.4
Blind	26.6	.1	3,132	44.5	0.1	11,067	36.0
Disabled	2,471.2	9.1	4,924	3,144.8	7.7	9,276	3.5
Children in AFDC families	353.2	1.3	460	531.8	1.3	591	22.4
Adult in AFDC families	348.1	1.3	613	598.4	1.5	849	39.8
Other title XIX recipients	432.8	1.6	360	594.5	1.4	603	11.7
Total, medically needy	7,934.6	29.1	2,145	11,235.5	27.4	3,073	15.1
Total	27,204.3	100.0	1,238	41,027.3	100.0	1,822	22.6

[1] Adjusted for inflation using the CPI–U index.

Notes: Total may not add due to rounding. Based on data which includes Puerto Rico and the Virgin Islands.

TABLE 13.—MEDICAID RECIPIENTS AND PAYMENTS BY BASIS OF ELIGIBILITY, PRELIMINARY ESTIMATES, FISCAL YEAR 1986

	Amount (in millions)	Percent of total	Recipients (in thousands)	Percent of total	Per capita payments
Age 65 and over	$15,099.6	36.8	3,139.9	13.9	$4,809.1
Blind	277.4	0.7	81.5	0.4	3,402.7
Disabled	14,646.6	35.7	3,099.7	13.8	4,725.2
Dependent children under age 21	5,135.7	12.5	10,030.7	44.5	512.0
Adults in families with dependent children	4,876.8	11.9	5,646.6	25.1	863.7
Other title XIX	990.7	2.4	1,365.9	6.1	725.3
Total	41,027.3	100.0	22,517.7	100.0	1,822.0

[1] Total is unduplicated count of recipients. A small number of recipients are in more than one category during the year.

[2] The percent of recipients is based upon the unduplicated count.

Notes: Totals may not add due to rounding. Based on data which include Puerto Rico and the Virgin Islands.

Source: HCFA, Office of the Actuary, Office of Medicaid Estimates and Statistics, Division of Medicaid Statistics.

TABLE 14.—MEDICAID PAYMENTS AND PER CAPITA PAYMENTS BY BASIS OF ELIGIBILITY, PRELIMINARY ESTIMATES, FISCAL YEARS 1981 TO 1986

[Amounts in millions of nominal dollars]

	1981	1982	1983	1984	1985	1986	Real percentage change, 1981–86 [1]
Age 65 and over	$9,926.1	$10,739.1	$11,953.9	$12,815.4	$14,096.3	$15,099.8	23.7
Blind	154.0	172.5	183.2	218.9	249.4	277.4	46.4
Disabled	9,300.8	10,232.8	11,184.2	11,758.3	13,202.8	14,646.8	28.0
Dependent children under age 21	3,508.3	3,473.5	3,835.7	3,978.6	4,414.3	5,135.7	19.0
Adults in families with dependent children	3,762.6	4,093.1	4,486.6	4,419.8	4,746.4	4,876.8	5.4
Other title XIX	552.5	688.5	747.4	700.0	798.4	990.7	45.8
Total	27,204.3	29,399.5	32,391.0	33,890.9	37,507.6	41,027.3	22.6
Per capita payment (nominal dollars)							
Age 65 and over	2,948.4	3,314.8	3,545.4	3,957.5	4,605	4,809	32.6
Blind	1,787.0	2,046.8	2,378.4	2,765.5	3,106	3,403	55.1
Disabled	3,107.8	3,646.3	3,931.9	4,149.2	4,496	4,725	23.6
Dependent children under age 21	366.2	363.2	402.3	410.8	453	512	13.3
Adults in families with dependent children	725.4	764.2	802.2	789.3	860	864	−3.2
Other title XIX	405.0	480.2	662.2	589.9	658	725	45.5
Average	1,237.7	1,360.9	1,502.8	1,568.5	1,720	1,822	19.7

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[1] Adjusted for inflation based on the CPI–U index.

TABLE 15.—MEDICAID PAYMENTS BY SERVICE CATEGORY, FISCAL YEARS 1981 AND 1986

	1981		1986		Real percent change, 1981–86
	Amount (in millions)	Percent of total	Amount (in millions)	Percent of total	
Inpatient hospital	$8,071.4	29.7	$11,481.0	28.0	15.6
General	(7,194.4)	(26.4)	(10,369.8)	(25.3)	(17.2)
Mental [1]	(877.0)	(3.2)	(1,111.2)	(2.7)	(−3.0)
Skilled nursing facilities	4,035.4	14.8	5,655.7	13.8	13.9
Intermediate care facilities [1]	7,502.9	27.6	11,861.7	29.0	28.7
Facilities for the mentally retarded [1]	(2,996.2)	(11.0)	(5,081.4)	(12.4)	(37.9)
Other [1]	(4,506.7)	(16.6)	(6,780.3)	(16.5)	(22.3)
Physician	2,101.4	7.7	2,548.2	6.2	−1.4
Dental [1]	542.7	2.0	531.9	1.3	−20.3
Other practitioner [1]	228.0	0.8	251.6	0.6	−10.3
Outpatient hospital	1,409.1	5.2	1,982.9	4.8	14.4
Clinic [1]	373.4	1.4	810.0	2.0	76.4
Lab and X-ray	147.3	0.5	424.4	1.0	134.2
Home health	427.8	1.6	1,352.1	3.3	157.0
Prescribed drugs [1]	1,534.7	5.6	2,691.9	6.6	42.6
Family planning	139.6	0.5	225.6	0.5	31.4
Early and periodic screening	67.1	0.2	102.4	0.2	24.1
Rural health clinics	4.1	([3])	10.1	0.0	100.3
Other [2]	619.5	2.3	1,098.0	2.7	44.1
Total	27,204.3	100.0	41,027.3	100.0	22.6

[1] Optional services. [2] Predominantly optional services. [3] Less than 0.1.

Notes: Totals may not add due to rounding. Based on data which includes Puerto Rico and the Virgin Islands. Inflation adjustment based on CPI–U index.

Source: HCFA, Office of the Actuary, Office of Medicaid Estimates and Statistics, Division of Medicaid Statistics Branch.

TABLE 16.—AVERAGE EXPENDITURE PER RECIPIENT FOR CATEGORICALLY NEEDY PERSONS WHO ARE ALSO RECEIVING AN SSI OR AFDC PAYMENT BY BASIS OF ELIGIBILITY, BY STATE, FISCAL YEAR 1986

State	Total	SSI aged	SSI blind	SSI disabled	AFDC child	AFDC adult
United States	1,300	2,253	2,641	3,764	521	952
All jurisdictions	1,268	2,253	2,633	3,690	511	916
Alabama	906	992	1,418	1,813	326	755
Alaska	2,986	8,549	6,555	12,269	775	1,481
Arkansas	1,600	1,527	2,359	3,415	597	864
California	1,018	1,031	1,668	2,724	397	898
Colorado	2,017	3,749	13,040	5,879	399	724
Connecticut	970	1,727	3,564	3,260	590	1,130
Delaware	1,320	2,881	3,496	3,939	496	984
District of Columbia	1,412	5,330	2,015	4,670	368	702
Florida	1,188	1,584	1,855	2,865	360	805
Georgia	1,312	1,529	2,253	2,857	425	1,138
Hawaii	924	2,009	3,361	3,467	406	930
Idaho	757	1,301	1,200	2,061	450	975
Illinois	1,163	2,818	3,848	4,858	466	941
Indiana	1,433	3,717	3,609	6,139	604	1,406
Iowa	1,134	1,880	1,825	4,216	478	926
Kansas	1,123	819	2,190	3,674	337	671
Kentucky	1,030	1,176	1,842	2,483	356	782
Louisiana	1,364	1,893	2,498	3,651	471	1,112
Maine	1,301	2,283	2,176	3,711	462	1,030
Maryland	1,251	2,455	2,238	3,427	656	1,175

Massachusetts	1,995	2,798	2,340	5,669	719	1,287
Michigan	1,073	2,143	2,785	3,771	473	1,126
Minnesota	1,709	5,134	7,087	9,776	443	1,075
Mississippi	816	1,373	1,657	1,815	303	718
Missouri	610	1,036	1,478	1,596	434	692
Montana	1,406	3,337	2,752	4,341	469	1,892
Nebraska	1,338	3,163	4,916	4,368	505	1,022
Nevada	1,745	1,446	3,124	5,450	635	1,306
New Hampshire	1,685	1,333	6,820	6,116	321	966
New Jersey	1,388	3,108	2,791	4,509	477	1,186
New Mexico	1,380	1,518	4,170	3,186	593	1,240
New York	2,168	6,390	11,693	6,501	670	1,316
North Carolina	1,239	2,072	3,077	3,849	468	922
North Dakota	2,057	4,292	2,728	6,941	542	1,211
Ohio	1,316	3,733	2,966	4,873	1,211	358
Oklahoma	854	1,806	1,608	2,523	276	448
Oregon	883	2,627	2,620	2,615	380	941
Pennsylvania	1,131	2,704	2,108	3,384	452	871
Rhode Island	1,240	3,030	3,077	3,670	379	807
South Carolina	1,039	1,196	1,480	2,330	337	811
South Dakota	1,885	2,768	3,033	5,520	556	1,053
Tennessee	1,405	1,329	2,106	2,631	673	1,293
Texas	1,410	1,876	2,704	4,006	423	1,105
Utah	1,283	3,133	2,731	5,697	430	974
Vermont	1,440	2,011	1,599	4,441	385	882

TABLE 16.—AVERAGE EXPENDITURE PER RECIPIENT FOR CATEGORICALLY NEEDY PERSONS WHO ARE ALSO RECEIVING AN SSI OR AFDC PAYMENT BY BASIS OF ELIGIBILITY, BY STATE, FISCAL YEAR 1986—Continued

State	Total	SSI aged	SSI blind	SSI disabled	AFDC child	AFDC adult
Virginia	1,290	2,298	2,325	3,436	370	882
Washington	1,137	6,399	6,273	16,359	491	929
West Virginia	654	988	1,491	1,073	370	556
Wisconsin	1,078	1,631	4,479	3,627	382	573
Wyoming	1,030	2,416	700	2,725	511	956
Puerto Rico	86	....	277	96	96	72
Virgin Islands	280	532	370	646	195	325

Source: HCFA, Office of the Actuary, Division of Medicaid Cost Estimates, Medicaid Statistics Branch.

TABLE 17A.—OPTIONAL MEDICAID SERVICES AND NUMBER OF STATES [1] OFFERING EACH SERVICE AS OF OCTOBER, 1986

Service	States offering service to categorically needy only	States offering service to both categorically and medically needy	Total
Podiatrists' services	10	31	41
Optometrists' services	15	35	50
Chiropractors' services	8	20	28
Other practitioners' services	10	25	35
Private duty nursing	5	14	19
Clinic services	14	35	49
Dental services	13	29	42
Physical therapy	8	28	36
Occupational therapy	5	22	27
Speech, hearing and language disorder	7	26	33
Prescribed drugs	14	37	51
Dentures	9	27	36
Prosthetic devices	12	35	47
Eyeglasses	13	34	47
Diagnostic services	4	19	23
Screening services	2	14	16
Preventive services	3	19	22
Rehabilitative services	8	26	34
Services for age 65 or older in mental institution:			
A. Inpatient hospital services	16	25	41
B. SNF services	9	14	23
C. ICF services	11	17	28
Intermediate care facility services	18	32	50
ICF for mentally retarded	18	31	49
Inpatient psychiatric services for under age 22	9	26	35
Christian science nurses	1	5	6
Christian science sanitoria	5	13	18
SNF for under age 21	15	33	48
Emergency hospital services	15	29	44
Personal care services	7	22	29
Transportation services	10	28	38
Case management services	0	1	1
Hospice services	0	1	1

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[1] States do not include Arizona, American Samoa, or Puerto Rico (offers only one service) but does include Guam, Northern Mariana Islands, and Virgin Islands. Thus maximum number is 53.

Source: Department of Health and Human Services.

TABLE 17B.—NUMBER OF OPTIONAL SERVICES COVERED, BY STATE, OCTOBER 1986

	Number of additional optional services offered to—	
	Categorically needy only	Both categorically and medically needy
Alabama	14	0
Alaska	16	0
Arizona	NA	NA
Arkansas	6	14
California	0	29
Colorado	16	0
Connecticut	0	24
Delaware	14	0
District of Columbia	0	25
Florida	0	17
Georgia	0	13
Hawaii	0	22
Idaho	14	0
Illinois	0	27
Indiana	28	0
Iowa	4	18
Kansas	0	22
Kentucky	0	23
Louisiana	7	9
Maine	2	23
Maryland	0	17
Massachusetts	0	30
Michigan	0	26
Minnesota	0	29
Mississippi	10	0
Missouri	13	0
Montana	0	27
Nebraska	0	23
Nevada	24	0
New Hampshire	0	26
New Jersey	8	20
New Mexico	16	0
New York	0	26
North Carolina	0	20
North Dakota	0	24
Ohio	25	0
Oklahoma	0	16
Oregon	0	25

TABLE 17B.—NUMBER OF OPTIONAL SERVICES COVERED, BY STATE, OCTOBER 1986—Continued

	Number of additional optional services offered to—	
	Categorically needy only	Both categorically and medically needy
Pennsylvania	4	12
Rhode Island	2	10
South Carolina	0	17
South Dakota	16	0
Tennessee	0	20
Texas	0	15
Utah	0	26
Vermont	0	18
Virginia	4	11
Washington	3	20
West Virginia	0	18
Wisconsin	14	12
Wyoming	9	0

Source: Department of Health and Human Services.
Note: See table 17A for list of optional services. The maximum number of additional optional services is 32.

TABLE 18.—ORBA86 SUMMARY STATUS: COVERAGE OPTIONS FOR PREGNANT WOMEN AND CHILDREN AS OF JANUARY 1988

	OBRA86 summary status						
	Adopted/ percent poverty	Coverage to age— 1	Coverage to age— 2	Dropped assets test	Continuous eligibility	Presumptive eligibility	Effective date
Alabama							
Alaska							
Arizona	100		×	×	×		1/88
Arkansas	[1] 75/100		×		×	×	4/87
California							
Colorado							
Connecticut	100	×					[2] 4/88
Delaware	100	×		×	×		1/88
District of Columbia	100		×	×	×		4/87
Florida	100		×	×	×	×	10/87
Georgia							
Hawaii							
Idaho							

TABLE 18.—ORBA86 SUMMARY STATUS: COVERAGE OPTIONS FOR PREGNANT WOMEN AND CHILDREN AS OF JANUARY 1988—Continued

	OBRA86 summary status						
	Adopted/percent poverty	Coverage to age—		Dropped assets test	Continuous eligibility	Presumptive eligibility	Effective date
		1	2				
Illinois							
Indiana							
Iowa							
Kansas							
Kentucky	100		×				10/87
Louisiana							
Maine						×	
Maryland	100	×		×	×	×	7/87
Massachusetts	100		×	×	×	×	7/87
Michigan	100		×	×	×		1/88
Minnesota				×	×		
Mississippi	100		×		×		10/87
Missouri	100		×		×		1/88
Montana							
Nebraska							
Nevada							
New Hampshire							
New Jersey	100		×	×	×	×	7/87
New Mexico	100		×		×		1/88
New York						×	
North Carolina	100		×	×	×	×	10/87
North Dakota							
Ohio	100	×					1/89
Oklahoma	100		×	×	×		1/88
Oregon	[1] 85/100		×	×	×		11/87
Pennsylvania	100		×	×		×	[2] 4/88
Rhode Island	100		×	×	×		4/87
South Carolina	100	×		×	×		10/87
South Dakota							
Tennessee	100		×		×	×	7/87
Texas							
Utah	100		×	×	×	×	[2] 4/88
Vermont	100		×				10/87
Virginia							
Washington	90		×		×		7/87
West Virginia	100		×	×	×		7/87
Wisconsin						×	

TABLE 18.—ORBA86 SUMMARY STATUS: COVERAGE OPTIONS FOR PREGNANT WOMEN AND CHILDREN AS OF JANUARY 1988—Continued

	OBRA86 summary status						
	Adopted/percent poverty	Coverage to age— 1	Coverage to age— 2	Dropped assets test	Continuous eligibility	Presumptive eligibility	Effective date
Wyoming							
Total	26	5	21	17	22	12	

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[1] These States will increase their income thresholds to 100 percent of poverty during 1988.

[2] Projected implementation date.

Source: National Governors' Association, 1988.

HOUSING ASSISTANCE

The Federal Government subsidizes the shelter costs of lower-income households primarily through rental assistance programs administered by the Department of Housing and Urban Development (HUD)—the Section 8 rental assistance program and public housing. (A small number of households also receives aid under similar programs that are now largely inactive.) The Section 8 and public housing programs both assist primarily families with children and elderly individuals and couples with incomes less than 50 percent of the median income for all families in the area in which they live, although households with incomes up to 80 percent of the area's median are also eligible. Thus, virtually all recipients of AFDC and SSI are eligible for housing assistance. Housing assistance is not available on an entitlement basis, however, and only a relatively small fraction of all eligible households receive aid.

SECTION 8 RENTAL ASSISTANCE

The Section 8 rental assistance program, authorized in 1974, subsidizes the rents of lower income households living in privately owned newly built, rehabilitated, or already-existing physically standard housing. Under most of the program variants, assisted households pay a fixed percentage of their income for shelter—generally 30 percent of income, after certain deductions. The Federal Government pays the owners of the housing the difference between the tenant's contribution and the full market rent, which must be less than HUD-established maximums. (Under the housing voucher program—a variant of the Section 8 existing-housing program—households may rent more costly units, paying the additional expense themselves. Voucher recipients choosing physically standard dwellings that rent for less than the benchmark levels may reduce their shelter costs to less than 30 percent of their incomes.)

PUBLIC HOUSING

Under the public housing program, which was authorized in 1937, the Federal Government pays the full development and financing costs for newly built or rehabilitated rental housing projects that are owned by local housing agencies and made available to lower income households at rental charges comparable to those paid by Section 8 tenants. In addition to covering all development and financing costs, the Federal Government also provides local housing agencies with annual operating subsidies to make up the difference between tenants' rent payments and the expense of maintaining the projects.

RECENT TRENDS IN FUNDING AND PROGRAM COVERAGE

Under current funding practices, each year the Federal Government makes long-term assistance commitments to aid some number of additional low-income households under the Section 8 and public housing programs. The new commitments add to the number of eligible households receiving assistance and contribute to higher Federal outlays for many years to come.

For each of the past 10 years, the Federal Government has made commitments to aid an average of about 170,000 additional households under the Section 8 and public housing programs—ranging from a high of more than 350,000 additional households aided in 1977 to a low of 54,000 additional households assisted in 1983 (see table 19). As a result of these recent commitments, the total number of low-income households receiving aid under these and predecessor programs has increased sharply, to 4.2 million households in fiscal year 1987.[18] As a result, outlays for HUD's housing assistance programs grew quickly—from $2.9 billion in fiscal year 1977 to $11.2 billion in 1987.

Despite this growth in program coverage, only a minority of all eligible households receives assistance. Currently, about one-third of all renters with incomes below 50 percent of the local median—the primary target groups for housing aid—is receiving assistance. Fewer than 1 in 10 of all renters with incomes between 50 percent and 80 percent of the area median is receiving housing aid.

TABLE 19.—FUNDING AND PARTICIPATION IN FEDERAL HOUSING ASSISTANCE PROGRAMS

[Dollars in millions]

Fiscal year	Net additional households for which funds have been reserved (in thousands) [1]	Total number of households receiving aid at end of year (in thousands) [2]	Budget authority appropriated to fund additional households assisted [3]	Outlays to fund all households receiving aid during the year [4]
1977	354	2,650	$27,983	$2,928
1978	317	2,818	31,484	3,592
1979	303	3,032	24,396	4,192
1980	188	3,268	26,680	5,331
1981	159	3,297	24,951	6,655
1982	56	3,508	13,275	7,867
1983	54	3,663	8,651	9,308
1984	88	3,860	9,298	9,889

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[18] This figure includes a small number of households who receive homeownership subsidies.

TABLE 19.—FUNDING AND PARTICIPATION IN FEDERAL HOUSING ASSISTANCE PROGRAMS—Continued

[Dollars in millions]

Fiscal year	Net additional households for which funds have been reserved (in thousands)[1]	Total number of households receiving aid at end of year (in thousands)[2]	Budget authority appropriated to fund additional households assisted[3]	Outlays to fund all households receiving aid during the year[4]
1985	103	3,943	9,932	11,178
1986	99	4,077	8,730	11,202
1987	93	4,151	7,330	11,154

[1] Includes subsidy commitments made under the Section 8 and public housing programs.

[2] Includes households assisted under the Section 8 and public housing programs, as well as those aided under the Section 235 program, the Section 236 program, the Section 221(d)(3)-Below Market Interest Rate program, and rent supplements.

[3] All figures are net of rescissions; the 1986 figure is net of funds sequestered under provisions of the Balanced Budget and Emergency Deficit Control Act of 1985. Figures do not include funds provided under the Rental Rehabilitation and Housing Development Grant Programs.

[4] Includes outlays from the subsidized housing and public housing operating subsidy budget accounts.

Source: Budget documents of the Department of Housing and Urban Development.

SCHOOL LUNCH AND BREAKFAST PROGRAMS

The National School Lunch Program (NSLP) and the School Breakfast Program (SBP) provide financial assistance to participating public and private schools that serve meals to children.[19] Each program has a three-tiered reimbursement system that allows children from households with incomes at or below 130 percent of the poverty line to receive free meals, permits children with incomes between 130 percent and 185 percent of poverty to receive meals at a reduced price, and provides a small subsidy for the meals of children with incomes above 185 percent of poverty.[20] Children in AFDC families are automatically eligible to receive free breakfast and lunch. An estimated 49.2 percent of households receiving AFDC also receive free or reduced-price meals.[21]

The NSLP provides subsidized lunches to children in most schools. During fiscal year 1986, the average daily participation was 23.7 million students, at a total Federal program cost of $3.17 billion (see table 20). In 1986, approximately 87 percent of all elementary and secondary school students were estimated to be in schools that participated in the NSLP; approximately 59 percent of the students in those schools participated in the program. Roughly half of the meals subsidized by the NSLP go to children from low-

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[19] These programs also provide some assistance in the form of commodities.

[20] For example, in the 1987-1988 school year, the NSLP schools receive Federal reimbursements of 140.5, 100.5 and 13.5 cents, respectively, for each lunch served to children from these three income categories. An additional 12.0 cents worth of commodity assistance is mandated for all lunches, regardless of the family income of the recipient. The corresponding levels of Federal reimbursement in the SBP are 76.25, 46.25 and 13.5 cents. Rates are 15 cents higher for free and reduced-price meals served in schools meeting certain "severe need" criteria. Commodity assistance valued at 3 cents per breakfast is offered if USDA supplies are available.

[21] Other programs that provide nutritional assistance to children include the Child Care Food Program, the Summer Food Service Program, and the Special Milk Program.

and moderate-income families; in fiscal year 1986, 42 percent of the children receiving NSLP lunches received free lunches, 7 percent received reduced-price lunches, and the remaining 51 percent paid full price for their meals.

The SBP serves far fewer students than does the NSLP. In fiscal year 1986, the program had an average daily participation of 3.5 million students, with total Federal program costs of $412 million (See table 21). In 1986, the program was estimated to be available in about 35 percent of all schools, and to serve about 22 percent of the participating schools' enrollment. The SBP also differs from the NSLP in that most of the schools that offer the program are in low-income areas, and the children who participate in the program are predominantly from low- and moderate-income families. In fiscal year 1986, almost 90 percent of the SBP participants received free or reduced-price breakfasts.

TABLE 20.—THE NATIONAL SCHOOL LUNCH PROGRAM: PARTICIPATION AND FEDERAL COSTS, FISCAL YEARS 1977–87

[Dollars in millions]

Fiscal year	Participation 9 month average (in millions) [1]				Federal costs [4]
	Free meals	Reduced-price meals	Full-price meals [2]	Total [3]	
1977	10.5	1.3	14.5	26.3	$2,111.1
1978	10.3	1.5	14.9	26.7	2,293.6
1979	10.0	1.7	15.3	27.0	2,659.0
1980	10.0	1.9	14.7	26.6	3,051.9
1981	10.6	1.9	13.3	25.8	2,959.5
1982	9.8	1.6	11.5	22.9	2,611.5
1983	10.3	1.5	11.2	23.0	2,835.5
1984	10.3	1.5	11.5	23.4	2,953.5
1985	9.9	1.6	12.1	23.6	3,045.1
1986	10.0	1.6	12.2	23.7	3,172.6
1987 (estimate)	10.1	1.6	12.3	24.0	3,347.3

[1] In order to reflect participation for the actual school year (September through May), these estimates are based on 9 month averages of October through May, plus September, rather than averages of the 12 months of the fiscal year (October through September). Fiscal year 1987 participation is estimated based on 8 month average participation from October 1986 through May 1987.

[2] The Federal Government provides a small subsidy for these meals.

[3] Details may not sum to total because of rounding.

[4] Includes cash payments and entitlement commodities, does not include the value of bonus commodities.

Source: U.S. Department of Agriculture, Food and Nutrition Service, "Annual Historical Review of FNS Programs: Fiscal Year 1986" and U.S. Department of Agriculture, Food and Nutrition Service, "Food Program Update for August 1987." Appendix (Nov. 1987).

TABLE 21.—THE SCHOOL BREAKFAST PROGRAM: PARTICIPATION AND FEDERAL COSTS, FISCAL YEARS 1977–87

[Dollars in millions]

Fiscal year	Participation 9 month average (in millions) [1]				Federal costs
	Free meals	Reduced-price meals	Full-price meals [2]	Total [3]	
1977	2.0	0.1	0.4	2.5	$148.6
1978	2.2	.2	.4	2.8	181.2
1979	2.6	.2	.5	3.3	231.0
1980	2.8	.3	.6	3.6	287.8
1981	3.1	.3	.5	3.8	331.7
1982	2.8	.2	.4	3.3	317.3
1983	2.9	.2	.3	3.4	343.8
1984	2.9	.2	.4	3.4	364.0
1985	2.9	.2	.4	3.4	385.3
1986	2.9	.2	.4	3.5	412.0
1987 (estimate)	3.1	.2	.4	3.7	453.7

[1] In order to reflect participation for the actual school year (September through May), these estimates are based on 9 month averages of October through May, plus September, rather than averages of the 12 months of the fiscal year (October through September). 1987 participation estimates based on 8 month average participation from October 1986 through May 1987.

[2] The Federal Government provides a small subsidy for these meals.

[3] Details may not sum to totals due to rounding.

Source: U.S. Department of Agriculture, Food and Nutrition Service, "Annual Historical Review of FNS Programs: Fiscal Year 1986," and U.S. Department of Agriculture, Food and Nutrition Service, "Food Program Update for August 1987." Appendix (Nov. 1987).

THE SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)

The Supplemental Food Program for Women, Infants, and Children (WIC) provides food assistance and nutritional screening to low-income pregnant and postpartum women and their infants, as well as to low-income children up to age 5. Participants in the program must have incomes at or below 185 percent of poverty, and must be nutritionally at risk.[22] Under the Child Nutrition Act of 1966, nutritional risk is defined as detectable abnormal nutritional conditions; documented nutritionally-related medical conditions; health-imparing dietary deficiencies; or conditions that predispose people to inadequate nutrition or nutritionally related medical problems.

WIC, which is federally funded, but administered by State and local agencies, does not serve all who are eligible. In fiscal year 1986, Federal costs totaled $1.6 billion and the program served approximately 3.3 million women, infants, and children (see table 6). It is difficult to estimate what proportion of the eligible population this represents, however, primarily because it is not clear how large the eligible population is. While one can estimate the number of women, infants, and children whose incomes are below the maximum level for eligibility in the program, it is not easy to ascertain how many also meet the nutritional risk requirement. In July of 1987, the USDA released a report of the WIC eligibility study ("Estimation of Eligibility for the WIC Program") which found that in 1984, an estimated 9.6 million persons were income-eligible for the WIC program, and 7.5 million of those were estimated to be at nutritional risk. Thus, 7.5 million persons were fully eligible for the WIC program at that time. Another USDA study released in April of 1986 indicated that in 1985 about two-thirds of WIC participants had incomes below the poverty level.

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[22] Although States are free to set their upper income-eligibility limits between 100 percent and 185 percent of poverty, the majority (82 percent in 1985) use income cut-off levels of between 151 and 185 percent of poverty.

TABLE 22.—THE SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC): PARTICIPATION AND FEDERAL COSTS, FISCAL YEARS 1977–1987

[Dollars in thousands]

Fiscal year	Participation (in thousands)				Federal costs [2]
	Women	Infants	Children	Total [1]	
1977	165.0	213.0	471.0	848.0	$255.9
1978	240.0	308.0	633.0	1,181.0	379.6
1979	312.0	389.0	782.0	1,483.0	525.4
1980	411.0	507.0	995.0	1,913.0	724.7
1981	446.0	585.0	1,088.0	2,119.0	874.4
1982	478.0	623.0	1,088.0	2,189.0	948.2
1983	542.0	730.0	1,265.0	2,537.0	1,123.1
1984	657.0	825.0	1,563.0	3,045.0	1,386.3
1985	665.0	874.0	1,600.0	3,138.0	[2] 1,488.9
1986	712.0	945.0	1,655.0	3,312.0	1,580.5
1987 (estimate) [3]	748.0	1,018.0	1,658.0	3,424.0	1,663.6

[1] Details may not sum to totals due to rounding.

[2] Includes funding for WIC studies and surveys ($1.7 million in fiscal year 1985 and $2.3 million in fiscal year 1986).

[3] Estimate based on average monthly participation October 1986 through August 1987.

Source: U.S. Department of Agriculture, Food and Nutrition Service, "Annual Historical Review of FNS Progams: Fiscal Year 1986," and U.S. Department of Agriculture, Food and Nutrition Service, "Food Program Update for August 1987" (Appendix), Nov. 1987.

JOB TRAINING PARTNERSHIP ACT

Title II-A of the Job Training Partnership Act of 1982 (JTPA) provides block grants to States to fund training and related services for economically disadvantaged youths and adults. These activities are administered by States and localities, which select participants and design projects within Federal guidelines. (Other titles of the act authorize the Job Corps and summer programs for young people; federally administered programs for Native Americans, migrant and seasonal farm workers, and military veterans; and a program for dislocated workers.)

The aid is intended to increase participants' future employment and earnings and reduce their dependence on welfare. Services authorized under this title include institutional and on-the-job training, job search assistance, counseling, and other work-related assistance. At least 90 percent of the participants must be economically disadvantaged, which is defined as being a member of a family whose total income for the 6-month period prior to application (exclusive of unemployment compensation, child support payments, and welfare payments) does not exceed the higher of the poverty line or 70 percent of the Bureau of Labor Statistics' lower living standard. Members of families receiving Aid to Families With Dependent Children (AFDC) or other cash welfare payments or food stamps are also defined as economically disadvantaged.

The act requires program operators to serve AFDC recipients at least in proportion to their share in the eligible population. Since the program was implemented in 1983, about one-fifth of the participants in activities authorized by Title II-A were AFDC recipients at the time that they enrolled—21 percent, for example, in program year 1985 (July 1985–June 1986).

In fiscal year 1988, about $1.8 billion is expected to be spent for JTPA II-A grants, providing training and other services to about 1.1 million participants. Annual outlays have ranged between $1.5 billion and $2.3 billion since JTPA was enacted. Under its predecessor, the Comprehensive Employment and Training Act (CETA), grants included funds for public service employment as well as training and were considerably larger.

HEAD START

Head Start began operating in 1965 under the general authority of the Economic Opportunity Act of 1964. Head Start provides a wide range of services to low-income children and their families in the context of a preschool child care program. Its goals are diverse and include both helping the children and their families with their present circumstances and lessening the disadvantages faced subsequently by many such children in school and work. The services provided include child care with a developmental orientation; physical, dental, and mental health services (including screening and immunizations); and nutritional and social services. Parental involvement is extensive, through both volunteer participation and employment of parents as Head Start staff. Formal training and certification as child care workers is provided to some parents through the Child Development Associate program.

Head Start primarily serves children between the ages of three and five and their families. The program's eligibility guidelines require that at least 90 percent of the children served come from families with incomes at or below the poverty line; furthermore, at least 10 percent of the children must be handicapped. Most children in AFDC families should be eligible for Head Start, although it is not known how many participate in or have access to the program. In fiscal year 1987, 451,732 children—about 17 percent of 3- to 5-year-old children living in poor families—were served in full-year Head Start programs, at a total Federal cost of $1.1 billion.[23]

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[23] If Head Start programs are enrolling the maximum number of nonpoor children permitted, the proportion of poor children served would be about 16 percent.

Only about one-fifth of those served were in full-day programs (more than 6 hours per day).

LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)

The predecessor to the Low-Income Home Energy Assistance Program (LIHEAP) was created by Title III of the Crude Oil Windfall Profit Tax Act of 1980 (P.L. 96-223). The purpose of LIHEAP is to help low-income households meet their energy-related expenses. In fiscal year 1981, $1.85 billion was appropriated for the program.

In 1981, title XXVI of the Omnibus Budget Reconciliation Act (OBRA) (Public Law 97-35), the Low-Income Home Energy Assistance Act of 1981, authorized the Secretary of Health and Human Services to make LIHEAP allotments to States for fiscal years 1982-1984. The Act permitted States to provide three types of energy assistance. States can: (1) help eligible households pay their home heating or cooling bills, (2) use up to 15 percent of their LIHEAP allotment for low-cost weatherization, and (3) provide assistance to households during energy-related emergencies.

The Human Services Reauthorization Act of 1984 (Public Law 98-558) amended the Low-Income Home Energy Assistance Act of 1981 and authorized appropriations for fiscal years 1985 and 1986. Appropriations for fiscal years 1982, 1983, and 1984 were $1.875, $1.975, and $2.075 billion, respectively. Public Law 98-619 appropriated $2.1 billion for fiscal year 1985. Public Law 99-178 appropriated $2.1 billion for fiscal year 1986.[24]

The Human Services Reauthorization Act of 1986, Public Law 99-425, amended the Act and extended the appropriations authorization through fiscal year 1990. Authorized appropriations levels are: $2.050 billion for fiscal year 1987; $2.132 billion for fiscal year 1988; $2.218 billion for fiscal year 1989; and $2.307 billion for fiscal year 1990. The appropriations for fiscal years 1987 and 1988 were $1.825 billion and $1.535 billion, respectively, including funding for Federal administration.

ALLOTMENTS TO STATES

States may transfer up to 10 percent of their LIHEAP allotment to one or any combination of the block grants for community services, title XX social services, preventive health and health services, primary health care, and maternal and child health services. A State's decision to transfer part of its allotment to a block grant does not affect its subsequent fiscal year allotment. The maximum amount of LIHEAP funds that a State can carry over to the next fiscal year is 15 percent. This provision applies to a State's allotment after adjustments have been made for tribal set aside and transfers to block grants. States must explain why funds are held over until the next fiscal year and what types of assistance the funds will provide. The amount carried over does not affect the State's subsequent fiscal year allocation. Amounts above 15 percent that are not spent by the State must be reallocated by the Secretary of Health and Human Services. Special allotment and set-aside rules apply to grants for Indian tribes and the territories.

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[24] The Balanced and Emergency Deficit Control Act of 1985, as reaffirmed by Public Law 99-366, required the cancellation of $90.3 million of fiscal year 1986 budget authority.

Table 23 shows State allotments for 1981 and recent fiscal years, and table 24 illustrates number of households receiving benefits from the single largest program component, heating assistance, average heating benefits and total dollars spent on heating assistance.

ELIGIBILITY AND TYPES OF ASSISTANCE

States have considerable discretion to determine eligibility criteria for LIHEAP and the types of energy assistance to be provided. At State option, LIHEAP payments can be made to households, based on categorical eligibility, where one or more persons are receiving: Supplemental Security Income, Aid to Families with Dependent Children, Veterans' Pensions, or Dependency and Indemnity Compensation. States can also elect to make payments to households with incomes that are less than 150 percent of the Federal poverty income guidelines or 60 percent of the State's median income, whichever is greater. Individuals who are denied benefits are entitled to an administrative hearing, except with regard to weatherization programs. The term "household" is defined as any individual or group of individuals who are living together as one economic unit and for whom residential energy is customarily purchased in common, or who make undesignated payments for energy in the form of rent. States cannot establish an income eligibility ceiling that is below 110 percent of the poverty level. States also are prohibited from treating categorically eligible and income eligible households differently with respect to LIHEAP. Further, LIHEAP benefits cannot be used to calculate income or resources, or affect other benefits, under Federal or State law, including public assistance programs.

States are required to give assurances that the largest benefits go to those households that have the lowest income and highest energy costs relative to their income, taking into account family size. In addition, States are to conduct outreach activities aimed at making households with elderly or handicapped individuals aware that energy assistance is available. These outreach services may include: toll-free information hotlines, special application periods, transportation to LIHEAP application offices, and home visits. Section 607(a) of Public Law 98-558 directs the Department of Health and Human Services to collect annual data, including information on the number of LIHEAP households in which at least one household member is 60 years old or handicapped.

States also have considerable discretion in the methods they have available to provide assistance to eligible households. Methods that are used, vary by State and program. A list of methods that are used includes cash payments, vendor payments, two-party checks, vouchers/coupons, and payments directly to landlords. When paying home energy suppliers directly, States are required to give assurances that suppliers will charge the eligible households the difference between the amount of the assistance and the actual cost of home energy. Also, States may use Federal funds to provide tax credits to energy suppliers who supply home energy to low-income households at reduced rates.

PLANNING AND ADMINISTRATION

States are required to submit an application for funds to the Secretary of Health and Human Services. As part of the annual application, the chief executive officer of the State is required to make several assurances related to eligibility requirements, anticipated use of funds, as well as to satisfy planning and administrative requirements. States are prohibited from using more than 10 percent of their total LIHEAP allotment for planning and administrative costs.

States must provide for public participation and public hearings in the development of the State plan, including making it, and any substantial revisions, available for public inspection and allowing public comment on the plan. Public Law 98-558 requires States to engage an independent person or organization to prepare an audit at least once every two years. However, the Single Audit Act of 1984 (P.L. 98-502) supersedes this requirement in most instances, and requires grantees to conduct an annual audit of all Federal financial assistance received. The law also contains two other related provisions. First, the Comptroller General is directed to evaluate, at least once every three years, whether a State's LIHEAP expenditures are consistent with law. Second, the Department of Health and Human Services is to develop regulations to prevent waste, fraud, and abuse in LIHEAP. (These regulations were published in final form on October 13, 1987.)

TABLE 23.—LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM STATE ALLOTMENTS

[In thousands of dollars]

States	Fiscal year—					
	1981 [1]	1984 [2]	1985 [2]	1986 [3]	1987 [4]	1988 [5]
Alabama	15,674	17,725	18,234	17,718	15,651	13,152
Alaska	7,505	7,034	7,247	10,815	9,990	8,395
Arizona	6,426	7,802	8,150	8,569	7,569	6,361
Arkansas	11,960	13,584	13,973	13,520	11,943	10,036
California	84,088	95,204	97,894	95,051	83,963	70,559
Colorado	29,319	33,299	33,299	31,692	29,275	24,602
Connecticut	38,247	43,440	43,440	41,344	38,191	32,094
Delaware	5,077	5,766	5,931	5,732	5,069	4,260
District of Columbia	5,940	6,746	6,940	6,437	5,931	4,984
Florida	25,921	28,163	28,970	28,035	24,765	20,811
Georgia	19,609	22,271	22,910	22,166	19,580	16,454
Hawaii	1,975	2,243	2,243	2,135	1,972	1,657
Idaho	11,181	12,877	12,877	12,362	11,419	9,596
Illinois	105,862	120,233	123,679	116,214	105,706	88,830
Indiana	47,431	54,438	55,371	52,207	47,861	40,220

TABLE 23.—LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM STATE ALLOTMENTS—Continued

[In thousands of dollars]

States	Fiscal year—					
	1981 [1]	1984 [2]	1985 [2]	1986 [3]	1987 [4]	1988 [5]
Iowa	29,470	38,581	38,581	36,720	33,919	28,504
Kansas	15,515	17,704	18,211	17,286	15,577	13,090
Kentucky	24,943	28,329	29,141	28,187	24,906	20,930
Louisiana	16,024	18,166	18,867	18,106	16,001	13,446
Maine	27,513	27,905	27,914	26,784	24,742	20,792
Maryland	29,285	33,261	34,214	33,104	29,242	24,574
Massachusetts	82,707	86,877	86,878	82,701	76,394	64,198
Michigan	111,598	114,081	113,951	110,067	100,358	84,336
Minnesota	72,409	82,239	82,239	78,271	72,302	60,759
Mississippi	13,930	15,246	15,683	15,190	13,418	11,276
Missouri	37,885	48,026	48,026	47,784	42,223	35,482
Montana	11,350	12,298	12,298	14,500	13,394	11,256
Nebraska	13,799	19,071	19,032	18,159	16,774	14,096
Nevada	3,560	4,036	4,151	4,024	3,555	2,987
New Hampshire	14,481	16,447	16,447	15,654	14,460	12,151
New Jersey	71,025	80,563	82,849	80,261	70,920	59,598
New Mexico	8,867	9,882	9,973	10,724	9,476	7,963
New York	231,907	263,291	263,291	250,683	231,565	194,596
North Carolina	34,561	39,253	40,378	39,067	34,510	29,001
North Dakota	7,995	14,530	14,612	15,751	14,550	12,227
Ohio	93,651	106,364	109,413	105,829	93,512	78,583
Oklahoma	15,998	15,558	16,004	16,286	14,387	12,090
Oregon	22,723	25,808	25,808	24,563	22,690	19,067
Pennsylvania	124,568	141,479	141,479	134,653	124,385	104,527
Rhode Island	12,594	14,220	14,220	13,613	12,575	10,567
South Carolina	13,822	14,138	14,544	14,072	12,430	10,446
South Dakota	10,241	11,168	11,434	12,793	11,817	9,931
Tennessee	25,267	28,697	29,520	28,561	25,230	21,202
Texas	41,261	46,862	48,206	46,641	41,200	34,623
Utah	13,289	14,827	14,827	14,727	13,604	11,432
Vermont	10,854	12,328	12,328	11,733	10,838	9,108
Virginia	39,019	40,516	41,677	39,907	35,620	29,934
Washington	33,104	40,847	40,896	40,403	37,321	31,363
West Virginia	16,507	18,748	19,285	17,934	16,483	13,851
Wisconsin	61,679	74,027	74,027	70,456	65,083	54,692
Wyoming	3,561	6,195	6,195	5,897	5,447	4,577
U.S. total	1,813,177	2,052,395	2,077,577	2,005,093	1,819,797	1,529,266

[1] Includes reallocation of funds and crisis intervention funds. Source: Low Income Energy Assistance Program; Report to Congress for Fiscal Year 1981; U.S. Department of Health and Human Services.

[2] Column does not add to total due to rounding. Source: U.S. Department of Health and Human Services, January 1985.

[3] State's final fiscal year 1986 allotments after reduction of $90.2 million required under Public Law 99-177 plus reallotment of $251,579 in fiscal year 1985 funds. Column does not add to total due to rounding. Source: U.S. Department of Health and Human Services, January 1987.

[4] Column does not add to total due to rounding. Source: U.S. Department of Health and Human Services, January 1987.

[5] Column does not add because of rounding: Source: U.S. Department of Health and Human Services, January 1988.

Note: Includes payments to Indian tribal organizations. Excludes Federal administrative costs and payments to territories.

TABLE 24.—HEATING ASSISTANCE BENEFITS, NUMBER OF HOUSEHOLDS ASSISTED, AND AVERAGE BENEFIT BY STATE

[Fiscal year 1987]

State	Heating assistance benefits (in thousands) [1]	Estimated number of households assisted	Estimated average benefit (in dollars)
Total	$1,292,159	6,317,266	NA
Alabama	9,915	109,000	$91
Alaska	5,377	11,223	480
Arizona	[2] 4,755	[2] 30,000	[2] 150
Arkansas	6,795	62,934	107
California	[2] 46,023	[2] 333,500	[2] 138
Colorado	[3] 18,755	65,000	289
Connecticut	35,644	75,000	475
Delaware	4,246	12,228	346
District of Columbia	3,296	15,000	232
Florida	[2] 18,092	[2] 170,436	[2] 106
Georgia	12,997	75,126	173
Hawaii	[4] 1,401	[4] 5,612	[4] 260
Idaho	7,924	38,295	207
Illinois	73,855	334,183	221
Indiana	39,943	143,976	254
Iowa	28,627	121,849	235
Kansas	9,985	50,226	199
Kentucky	10,467	97,010	108
Louisiana	7,057	64,800	108
Maine	17,139	56,932	301
Maryland	24,701	87,900	275
Massachusetts	77,460	142,000	540
Michigan	71,000	467,000	152
Minnesota	51,614	120,129	429
Mississippi	7,733	60,417	128
Missouri	36,302	143,880	252

TABLE 24.—HEATING ASSISTANCE BENEFITS, NUMBER OF HOUSEHOLDS ASSISTED, AND AVERAGE BENEFIT BY STATE—Continued

[Fiscal year 1987]

State	Heating assistance benefits (in thousands) [1]	Estimated number of households assisted	Estimated average benefit (in dollars)
Montana	8,593	23,815	378
Nebraska	8,991	34,017	264
Nevada	2,931	12,507	234
New Hampshire	10,617	23,414	453
New Jersey	50,071	155,000	327
New Mexico	9,045	50,000	50
New York	183,300	891,652	203
North Carolina	20,290	171,945	118
North Dakota	8,556	17,725	483
Ohio	51,146	386,918	132
Oklahoma	11,326	89,826	126
Oregon	16,977	85,000	190
Pennsylvania	[5] 92,089	[5] 392,692	235
Rhode Island	9,114	26,234	347
South Carolina	10,865	86,233	125
South Dakota	7,085	22,850	310
Tennessee	16,625	72,559	229
Texas	17,684	321,103	56
Utah	8,903	41,819	213
Vermont	7,845	18,000	435
Virginia	28,712	112,725	255
Washington	21,099	98,086	215
West Virginia	10,635	74,858	142
Wisconsin	44,188	201,741	219
Wyoming	4,007	12,891	311

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[1] State estimates of heating assistance obligations for FY 1987 from the following available funds: FY 1986 LIHEAP funds carried over for use in FY 1987; "oil overcharge" funds made available by States for use in LIHEAP; Federal LIHEAP allotments (net of set-asides for Indian tribes); and any State or other funds made available for LIHEAP heating assistance.

[2] Benefits for heating and cooling assistance combined.

[3] Includes approximately $591,000 for outreach.

[4] Households received energy assistance with no differentiation between heating and cooling assistance.

[5] State operates on a program year which spans two Federal fiscal years. For the 1986–1987 program year, the State used $98.045 million for heating assistance and assisted 418,036 households.

Source: U.S. Department of Health and Human Services, January 1988. Data compiled from telephone interviews with State offices conducted in August 1987.

VETERANS' BENEFITS AND SERVICES

The Veterans Administration (VA) offers a wide range of benefits and services to eligible veterans, members of their families, and survivors of deceased veterans. The VA programs include veterans compensation and veterans pensions—the main cash-assistance entitlement programs—readjustment and rehabilitation benefits, education and job training programs, medical care services, and the housing and loan guaranty programs. Also, the VA provides life insurance, burial benefits, and special counseling and outreach programs. In fiscal year 1987, Federal outlays for veterans' benefits and services were $26.8 billion.

VETERANS COMPENSATION AND VETERANS PENSIONS

Service-connected compensation is paid to veterans who have incurred injuries or illnesses while in service. The amounts of the monthly payments are determined by disability ratings that are based on presumed average reductions in earnings capacities caused by the disabilities. Disability ratings generally range from 10 percent to 100 percent in 10-percent intervals; multiple injuries may result in combined-degree ratings, however, and some injuries are compensable at a zero-percent rating. Death compensation or dependency and indemnity compensation is paid to survivors of veterans who died as a result of service-connected causes. In 1987, about 2.2 million disabled veterans and 330,000 survivors received $10.5 billion in compensation payments.

Veterans pensions are means-tested cash benefits paid to war veterans who are age 65 or older or who have become permanently and totally disabled from non-service-connected causes, and to survivors of war veterans. Under the current or "improved law" program, benefits are based on family sizes, and the pensions provide a floor of income: the basic benefit before subtracting other income sources is $8,140 in 1988 for a veteran with one dependent ($6,214 for a veteran living alone). Somewhat less generous benefits are available to survivors; a surviving spouse with no children could receive two-thirds of the basic benefit amount given a single veteran. About 1.3 millon persons received $3.8 billion in veterans pension payments in 1987.

READJUSTMENT, EDUCATION, AND TRAINING BENEFITS

Several Veterans Administration programs support readjustment, education, and job training for veterans and military personnel who meet certain eligibility criteria. The largest of these programs are the Vietnam-era GI bill, the post-Vietnam-era education program, and the All-Volunteer Force educational assistance program (Montgomery GI bill). Each program covers veterans of specific service-enrollment periods, and provides specific educational and vocational benefits, ranging from college courses to on-the-job training. The post-Vietnam-era education program (closed for new enrollments after March 1987) is funded by the Department of Defense appropriations and only administered by the VA. The job training program established in 1983 by the Emergency Veterans' Job Training Act provides payments to defray training costs of employers who hire certain wartime veterans who have been unemployed for long periods of time. Net outlays from the VA account in 1987 for all education and training programs came to $454 million.

MEDICAL PROGRAMS

The VA provides inpatient and outpatient medical and health-related services, and operates 172 hospital centers, 117 nursing homes, 17 domiciliaries, and 228 outpatient clinics. The VA extends free priority care to service-connected disabled veterans, to veterans in special categories, and to needy veterans—in 1988, those with incomes below $15,833 ($18,999 for a veteran with one dependent). Veterans eligible under these criteria are called "Category A" veterans, and they are entitled to hospital care. As facilities and other resources permit, the VA gives no-cost care to other non-service-connected veterans with incomes below $21,111 (about $26,389 for a veteran with one dependent). Medical care for higher income veterans requires copayments, and is available as long as resources permit. VA-operated nursing home care is augmented by VA-supported care under contract in private community nursing homes and with per diem payments for veterans in State-run homes for veterans.

The VA operates a nationwide health system. In 1987, the VA received approximately 2.9 million applications for care; about 1.1 million hospital patients and 103,600 nursing home and domiciliary patients were treated; and 21.9 million outpatient visits were provided. Construction and modernization of facilities, as well as medical research and training programs, are also funded through VA appropriations. In 1987, VA medical programs cost the Federal Government $10.3 billion (see table 25).

TABLE 25.—EXPENDITURES AND NUMBER OF RECIPIENTS OF VETERANS BENEFITS AND SERVICES, FOR SELECTED FISCAL YEARS [1]

Fiscal year	Compensation and pensions	Readjustment, education, job training	Medical programs [2]	Housing and loans
	Outlays (in billions of dollars)			
1975	7.4	4.6	3.7	([3])
1980	11.0	2.3	6.5	([3])
1981	12.2	2.3	7.0	0.2
1982	13.2	1.9	7.5	0.1
1983	13.7	1.6	8.3	([3])
1984	13.8	1.4	8.9	0.2
1985	14.1	1.1	9.5	0.2
1986	14.3	0.5	9.9	0.1
1987	14.3	0.5	10.3	0.3
	Recipients (in thousands)			
1975	4,855	2,804	1,985	290
1980	4,646	1,232	2,671	297
1981	4,535	1,074	2,765	188
1982	4,407	900	2,720	103
1983	4,286	755	2,933	245
1984	4,123	629	3,026	252

TABLE 25.—EXPENDITURES AND NUMBER OF RECIPIENTS OF VETERANS BENEFITS AND SERVICES, FOR SELECTED FISCAL YEARS [1]—Continued

Fiscal year	Compensation and pensions	Readjustment, education, job training	Medical programs [2]	Housing and loans
1985	4,005	491	2,963	179
1986	3,900	388	2,942	314
1987	3,850	352	2,900	479

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[1] The major programs funded through the Veterans Administration are included in the table; outlays for other, smaller programs, as well as general operating expenses, are not included. Outlays are net of receipts.

[2] Medical program expenditure data include outlays for direct medical services, medical research and training, and construction programs. Recipients are the number of applicants for all types of medical care during the year.

[3] Spending in this category was less than $50 million.

Source: Veterans Administration.

HOUSING AND LOAN PROGRAMS

The VA assists veterans in attaining home ownership through VA guarantees of mortgages and through direct loan programs. In the loan guaranty program, mortgage credit needs of veterans and service personnel may be satisfied by private lenders on more liberal terms than would be generally available to nonveterans. The Federal Government's guaranty replaces substantial down payments and other investment safeguards used by conventional mortgagers. In the event of foreclosure, the guaranty protects lenders against losses. The guarantee has been changed for all loan commitments made after December 31, 1987, to the following: for home loans of $45,000 or less, the guarantee is worth up to 50 percent of the loan amount; for loans over $45,000, the maximum guarantee is the lesser of 40 percent of the mortgage amount or $36,000, but at least $22,500 for such loans. Direct loans from the VA may also be available to persons who purchase properties acquired by the VA when veterans default on loans. To offset some of the costs of servicing the loans, a user fee equal to 1 percent of the mortgage amount is required. In 1987, the VA guaranteed about 479,500 such loans.

Special direct loans are made to certain totally disabled veterans in connection with grants to assist them in acquiring suitable housing. Only one such loan was processed for a severely disabled veteran in 1987. Other severely disabled veterans received grants to buy, build, or modify homes.

TRENDS IN USE AND COSTS

Veterans programs are undergoing shifts in the demand for services as a result of changing demographics and eligibility. The veteran population as a whole is decreasing in numbers—from about 29.5 million in 1975 to 27.5 million in 1987—but the number of veterans over age 65 is increasing rapidly—from about 2.2 million in 1975 to about 6.0 million in 1987 to an expected 7.2 million veterans by 1990. The use and cost of medical care, for example, are expected to grow more rapidly over the next several years than those of other veterans' benefits and services, unless constrained by discretionary appropriations. Compensation and pension caseloads are decreasing steadily due to beneficiary, deaths, terminations for excess incomes, and age limitations for dependents. In addition, GI bill participation is declining as Vietnam era veterans reach the delimiting period, when eligibility ceases.

Cost-of-living adjustments are usually appropriated for veterans compensation payments, while improved-law veterans pensions increase automatically each year at the same time and by the same percentage as Social Security benefits.

PART 2

TRUST FUNDS (OR SPECIAL FUNDS) WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS

Section 1. Black Lung Disability Trust Fund
Section 2. Airport and Airway Trust Fund
Section 3. Highway Trust Fund
Section 4. Aquatic Resources Trust Fund
Section 5. Harbor Maintenance Trust Fund
Section 6. Inland Waterways Trust Fund
Section 7. Hazardous Substance Superfund
Section 8. Leaking Underground Storage Tank Trust Fund
Section 9. Oil Spill Liability Trust Fund
Section 10. Land and Water Conservation Fund
Section 11. Wildlife Restoration Projects
Section 12. Reforestation Trust Fund
Section 13. Deep Seabed Revenue Sharing Trust Fund
Section 14. Tax Court Judges Survivors Annuity Fund
Section 15. Railroad Retirement System
Section 16. Railroad Unemployment Compensation System

Section 1. Black Lung Disability Trust Fund

LEGISLATIVE HISTORY AND JURISDICTION

National attention was focused on the working conditions of coal miners following a West Virginia coal mine accident in 1968 that killed 78 workers. Congressional hearings the following year on reform of the coal mine safety laws also examined the problems of coal workers' pneumoconiosis, or black lung disease. The Federal Coal Mine Health and Safety Act of 1969 established Federal minimum standards for mines in order to protect the safety and health of coal miners. In addition, title IV of the act provided benefits for miners totally disabled by black lung disease and for dependents of miners who had died from the disease or were totally disabled from the disease at death.

The 1969 act was the first effort, at any level of government, to provide benefits exclusively to the victims of a single occupational disease. This was also the first time the Federal Government took major responsibility in the traditionally State-administered area of workers' compensation. The 1969 act was amended by the Black Lung Benefits Act of 1972, the Black Lung Benefits Reform Act of 1977, the Black Lung Revenue Act of 1977, the Black Lung Benefits Revenue Act of 1981, and Public Law 99-272. Most recently Public Law 100-203 extended current coal excise tax rates through 2013.

The statutory provisions of the act as amended are contained in 30 U.S.C. sections 901 et seq. and in the Internal Revenue Code of 1954 sections 4121, 4218, 4952, 4953, and 9501, et seq.

There are two distinct programs of black lung benefits under title IV: part B and part C. The part B program is financed by Federal general revenues and is administered by the Social Security Administration (SSA). Benefits under part B are payable only for claims filed on or before June 30, 1973 (December 31, 1973, in the case of survivors), and thus no new beneficiaries can be added to the rolls. The part C program is administered by the Department of Labor (DOL) and generally applies to claims filed after June 30, 1973. Benefits under part C are paid either by the "responsible" coal mine operator or by the Black Lung Disability Trust Fund.

The Black Lung Disability Trust Fund was created in 1978 pursuant to the Black Lung Benefits Revenue Act of 1977 (Public Law 95-227). In 1981, the statutory provisions of the Black Lung Disability Trust Fund were transferred to the Internal Revenue Code by the Black Lung Benefits Revenue Act of 1981 (Public Law 97-119). The 1981 act, the 1986 Consolidated Omnibus Budget Reconciliation Act (Public Law 99-272), and the 1987 Ominbus Budget Reconciliation Act (Public Law 100-203) revised provisions governing the Trust Fund's Finance (i.e., excise tax rates on coal and interest on the debts owed by the Trust Fund).

The Committee on Ways and Means has jurisdiction over the excise tax on coal, the structure and administration of the Black Lung Disability Trust Fund, the expenditure purposes of the Trust Fund and tax provisions as to the coal mine operators' self-insurance trusts. The Committee on Education and Labor has jurisdiction over eligibility and evidentiary standards, claims adjudication, and related benefit provisions.

BENEFIT STRUCTURE

Generally, the Black Lung Disability Trust Fund ("Trust Fund") is required to pay benefits with respect to part C claims (claims filed *after* June 30, 1973) in which the miner's last coal mine employment was *before* January 1, 1970. Part B claims (claims filed on or *before* June 30, 1973) are generally paid by the Social Security Administration out of the general revenues of the Treasury, not the Trust Fund. If a miner's last coal mine employment was *after* January 1, 1970, and the claim was filed *after* June 30, 1973, benefits are paid by the coal mine operator judged to be responsible, the so-called "responsible operator," not the Trust Fund. However, the Trust Fund pays benefits if there is no responsible operator among the miner's employers or if the responsible operator is in default. Under the Black Lung Benefits Revenue Act of 1981, liability for certain claims which had been denied prior to March 1, 1978, but which were reviewed and approved under the liberalized eligibility criteria of the Black Lung Benefits Reform Act of 1977, was also transferred to the Trust Fund. When an operator is determined to be responsible for the payment of benefits which in fact have been paid out of the Trust Fund, then the operator is obligated to reimburse the Trust Fund for those amounts plus interest.

The expenses of the Department of Labor and the administrative expenses of the Department of Health and Human Services for the claims program financed through the Trust Fund are paid out of the Trust Fund moneys. The Trust Fund also bears the cost of its own administration as well as the costs of administering the collection of the excise tax on coal.

A claim under part B or C must meet three general conditions in order to be approved for black lung disability benefits: (1) the miner must have (or, if deceased, have had) pneumoconiosis; (2) the miner must be totally disabled by the disease (or must have been totally disabled at the time of death); and (3) the pneumoconiosis must have arisen out of coal mine employment. There are certain statutory presumptions that are used to establish eligibility.

TABLE 1.—NUMBER OF PART C BENEFICIARIES [1]

[Calendar years 1980 and 1984, September 1985 and 1986, and December 1987]

Class of beneficiary	1980	1984	1985	1986	1987
Primary beneficiaries:					
Miners	52,922	62,785	61,401	59,014	56,688
Widows	26,739	36,495	37,559	38,896	40,702
Others	1,189	854	882	925	997
Total primary beneficiaries	80,850	100,134	99,842	98,835	98,387
Dependents of primary beneficiaries	58,223	62,982	61,010	58,566	54,882
All beneficiaries	139,073	163,116	160,852	157,401	153,269

[1] Does not include those part B beneficiaries whose medical benefits are paid under part C. Includes cases (10,000 in 1986) where payment has been suspended and where a responsible coal mine operator is paying benefits.

Source: Department of Labor.

TABLE 2.—NUMBER OF PART B BENEFICIARIES

[December 1974–80, September 1984, 1985, 1986, and November 1987]

Class of beneficiary	1974	1980	1984	1985	1986	1987
Miners	169,097	120,235	87,385	79,443	71,849	63,573
Widows	134,700	146,603	141,382	138,902	135,738	131,561
Others	183,419	132,639	89,163	80,476	72,144	63,334
Total	487,216	399,477	317,930	298,821	279,731	258,468

Source: Social Security Bulletin.

The basic monthly benefit for a miner totally disabled from black lung or a survivor is 37½ percent of the monthly pay of a Federal employee in grade GS–2, step 1. A totally disabled miner or survivor with one dependent receives the basic monthly benefit rate increased by 50 percent. If the miner or survivor has two dependents, the benefit rate is increased by 75 percent, and if there are three or more dependents, the rate is increased by 100 percent. Benefit rates are revised each year to reflect any revision in Federal pay scales. Part B and part C benefit rates are the same except that, pursuant to a provision in the 1987 appropriation bill, part B benefits are rounded down to the nearest whole dollar. The monthly rates for part C as of January 1988 were:

Miner or one survivor—$344.80.
Miner or survivor with one dependent—$517.20.
Miner or survivor with two dependents—$603.40.
Miner or survivor with three dependents—$689.50.

Black lung benefits are not taxed by the Federal Government, although States may do so.

Reductions in black lung benefits or the offset of black lung benefits against other benefits are subject to significantly different rules depending upon whether the benefits are paid under part B or part C. Under part B, black lung benefits are reduced by any payments received under the workers' compensation, unemployment compensation or disability insurance laws of a State if such payments are for death or disability due to pneumoconiosis. If the State payments are made for reasons other than pneumoconiosis, black lung benefits are not reduced. Part C benefits are reduced for State or Federal workers' compensation (but *not* for unemployment compensation or disability insurance) in the same manner.

Under part B, miners or their parents, brothers or sisters (but not their spouse or children) have always been subject to an earnings test which causes their black lung benefits to be reduced as defined in section 203 of the Social Security Act (the same earnings test for Social Security recipients). This excess earnings offset does *not* apply to benefits payable under part C, unless the claim for benefits was filed on or after January 1, 1982.

Under part B, black lung benefits are not considered workers' compensation payments and therefore are not considered in calculating any Social Security disability payments under Title II of the Social Security Act. However under part C, exactly the opposite is the case, and black lung benefits must be taken into account.

Survivor benefits under the black lung program are not reduced as a result of Social Security survivor benefits.

A miner (but not a miner's family or survivors) receiving black lung cash benefits is eligible for medical and rehabilitation benefits including treatment and/or medications prescribed for the miner's black lung disease and directly associated illnesses. Medical costs are paid either by a responsible coal mine operator or by the Trust Fund, whichever is responsible for payment of regular monthly benefits.

FINANCING MECHANISM

A manufacturers' excise tax is imposed on domestically mined coal (other than lignite) which is sold or used by the producer (Internal Revenue Code sections 4121 and 4218). Prior to 1982, the rate of tax was the lesser of (1) 50 cents per ton for coal from underground mines and 25 cents per ton for coal from surface mines, or (2) 2 percent of the price for which the coal was sold. Under 1981 amendments (Public Law 97-119), the rate of tax was doubled to the lesser of (1) $1 per ton for coal from underground mines and 50 cents per ton for coal from surface mines, or (2) 4 percent of the price for which the coal is sold. These higher rates were to revert to the pre-1982 rates on January 1, 1996, or earlier if the Black Lung Disability Trust Fund became solvent (i.e., if the Trust Fund had paid off debts owed the Federal Treasury).

In 1986, the tax rates were increased to their current level: the lesser of (1) $1.10 per ton for coal from underground mines and 55 cents per ton for coal from surface mines, or (2) 4.4 percent of the price for which the coal is sold. As with the earlier tax rates, the current rates (enacted in Public Law 99-272) are to revert to pre-1982 rates on January 1, 1996, or earlier if the Black Lung Disability Trust Fund becomes solvent.

In 1987, Congress, through the Omnibus Budget Reconciliation Act (Public Law 100-203), extended the termination date for the coal excise tax rate. These higher rates are to revert to the pre-1982 rates on January 1, 2014, or earlier if the Trust Fund achieves solvency.

Amounts equal to the revenues from this excise tax (plus any revenues from the penalty tax on taxable expenditures from a coal mine operator self-insurance trust, described below) are automatically appropriated to the Black Lung Disability Trust Fund, for payment of benefits and other Trust Fund expenses.

A responsible operator may fund its liability for black lung benefits through deductible contributions to a qualified tax-exempt trust (code section 501(c)(21)), called coal mine operators' self-insurance trusts. Misuse of a trust due to self-dealing (code section 4951) and expenditures for an improper purpose (code section 4953), trigger certain penalty excise taxes. Amounts collected under these provisions, which in the past have been very small, are appropriated to the Black Lung Disability Trust Fund.

FINANCIAL STATUS OF TRUST FUND

The Trust Fund has been operating at a deficit since its establishment in 1978. As of fiscal year 1987 it is estimated the Trust Fund has paid nearly $6 billion in cash benefits and medical expenses, along with approximately $379 million in administrative costs. It also has accumulated over $1 billion in interest charges. At the same time, the excise tax on coal has generated only approximately $4 billion in revenues, leaving a cumulative deficit of $2.9 billion through fiscal year 1987. This deficit has been financed with advances from the general revenues of the U.S. Treasury. These advances must be repaid from future Trust Fund revenues. Through fiscal year 1985, interest on the cumulative advances to the Trust Fund was also due. However, Public Law 99–272 forgave Trust Fund interest payments for fiscal years 1986 through 1990. This, along with the 10-percent increase in tax rates (discussed above) and reduced benefit spending, substantially reduced the Trust Fund's borrowing (advance from the general fund) in fiscal year 1987.

Table 3 shows the status of the Trust Fund as of the end of fiscal year 1987.

TABLE 3.—STATUS OF BLACK LUNG DISABILITY TRUST FUND

[In thousands of dollars]

Fiscal year	Income			Outgo		
	Coal tonnage tax	Interest	Advances from general fund	Benefit payments	Administrative expenses	Interest or advances
Actual:						
1978	92,050	1,192	18,925	76,797	35,346	...
1979	221,614	122	400,809	582,038	32,149	7,740
1980	272,262	...	535,837	721,746	34,238	52,497
1981	236,635	...	554,778	644,288	35,585	109,488
1982	490,746	254	283,002	578,244	35,789	160,597
1983	493,685	321	357,773	623,129	34,936	193,273
1984	518,464	450	346,063	594,213	36,551	234,503
1985	581,390	573	335,545	583,422	40,229	274,751
1986	[1] 547,251	1,594	51,271	573,939	44,439	NA
1987	607,500	1,500	33,916	596,103	49,809	NA
Total	4,061,597	6,006	2,917,919	5,573,919	379,071	1,032,849

[1] Reflects inter-year adjustment, Actual coal tax revenues for 1985 were $561,746,000. For 1986, actual tax revenues totalled $566,845,000.

NA—Not applicable, interest forgiven.

Source: Fourth Annual Report on the Financial Condition and Results of Operations of the Black Lung Disability Trust Fund (Department of Treasury, September 30, 1981), and Budget of the U.S. Government. Appendixes for fiscal years 1984, 1985, 1986, 1987, and 1988.

Section 2. Airport and Airway Trust Fund

LEGISLATIVE HISTORY

1970 Act and 1971 Amendment

The Airport and Airway Trust Fund was established as of July 1, 1970, by the Airport and Airway Revenue Act of 1970 (Title II of the Airport and Airway Development Act of 1970, Public Law 91-258). The 1970 Act provided that new and increased aviation user taxes were to be deposited into the Trust Fund and, with interest earned on the deposits, were to be available to meet specified airport and airway obligations of the United States incurred under Title I of the 1970 Act, as it was in effect on the date of enactment. Amounts in the Trust Fund were available for making specified expenditures, as provided in appropriations acts, until July 1, 1980.

The 1970 Act authorized Trust Fund expenditures for the maintenance and operation of air navigation facilities, qualified airport planning and construction purposes, airway facilities and equipment, research and development, safety, and related departmental administrative expenses. However, a 1971 amendment (Public Law 92–174) to Title I of the 1970 Act removed the authority for spending Trust Fund moneys for maintenance and operation of the airway system. This amendment also limited the authority for meeting administrative costs from the Trust Fund to only such administrative expenses related to the remaining authorized purposes.

1973 Amendment

A 1973 amendment (Public Law 93–44) to Title I of the 1970 Act increased the authorization levels for airport grants for fiscal years 1974 and 1975, increased the Federal share for certain airport grants and safety and security equipment costs, and amended the definition of airport development to specifically include security equipment required under regulations of the Department of Transportation.

1976 Amendment

The Airport and Airway Development Act Amendments of 1976 (Public Law 94–353) further amended Title I of the 1970 Act to include several additional expenditure categories to be authorized from the Trust Fund. The new expenditure categories were: snow removal equipment; noise suppressing equipment; construction of physical barriers and landscaping for the purpose of reducing the effect of aircraft noise in areas adjacent to public airports; acquisition of land or property interests for airport noise control purposes; airport terminal development (the public, nonrevenue-producing areas, including baggage facilities and passenger moving equipment); and specified amounts for maintenance of airway facilities. Thus, the 1971 prohibition against authorizing airway operating and maintenance costs from the Trust Fund was partially removed by the 1976 amendment. In addition, the 1976 amendment provided authorization levels for airport grants and other existing Trust Fund expenditure programs through fiscal year 1980, and increased the Federal share for certain airport grants for fiscal years 1977 and 1978.

The Committee on Ways and Means offered a Committee amendment as Title III to the 1976 Act Amendments which amended the Trust Fund language to conform it to the authorization provisions approved by the Committee on Public Works and Transportation and to permit expenditures from the Fund to be made until October 1, 1980 (instead of July 1, 1980). The Committee on Ways and Means initially declined to allow expenditures from the Trust Fund for terminal facilities; however, this expenditure purpose was eventually approved by a separate vote of the House.

1979 Amendment

The Aviation Safety and Noise Abatement Act of 1979 (Public Law 96-193) further amended Title I of the 1970 Act to authorize Trust Fund appropriations for airport noise compatibility planning programs and airport noise compatibility grants and to increase the airport development authorization amounts for fiscal year 1980. In addition, the Act amended the Trust Fund language (section 208(f)(1)(A) of the Airport and Airway Revenue Act of 1970; 49 U.S.C. 1742(f)(1)(A)) to conform to the 1979 amendments.

1980 Amendment

In 1980, Public Law 96-298 was enacted to extend the aviation excise taxes and require the deposit of the revenues from these taxes into the Trust Fund from July 1, 1980 until October 1, 1980. In 1980, the Committee on Ways and Means also reported the Airport and Airway Revenue Act of 1980 as a Committee amendment, to be offered as Title II to H.R. 6721, in order to extend aviation excise taxes and the Trust Fund until October 1, 1985. However, the bill was not considered by the House prior to the adjournment of the 96th Congress. As a result, expenditures from the Trust Fund were not authorized after September 30, 1980; further, on October 1 many of the aviation excise taxes automatically expired or were reduced, and the deposit of the remaining aviation excise tax revenues into the Trust Fund was terminated.

1981 Amendment

In 1981, the Committee on Ways and Means approved a technical and conforming amendment to the Trust Fund provisions in order to allow expenditures to be made from the Trust Fund through September 30, 1981. The Committee amendment was included in H.R. 4182, the fiscal year 1981 Airport Development Authorization Act, which was approved by the House in July 1981. The provisions of H.R. 4182 were later enacted as part of the Omnibus Budget Reconciliation Act of 1981, Public Law 97-35.

Also in 1981, the House Committee on Public Works and Transportation approved H.R. 2643 to set funding levels for airport and airway programs for fiscal years 1982 and 1983. At the adjournment of the first session of the 97th Congress, a financing title for the bill was pending in the Committee on Ways and Means.

1982 Amendment

On May 12, 1982, the Committee on Ways and Means reported H.R. 4800 as a financing title for H.R. 2643; the bill extended and reinstated various aviation excise taxes and the Airport and Airway Trust Fund for the period July 1, 1982, through December 31, 1983.

Title V of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) contained the provisions of the Airport and Airway Improvement Act of 1982, authorizing spending out of the Trust Fund for airport programs at higher levels over the period fiscal years 1982 through 1987. Aviation excise tax provisions (similar to those in H.R. 4800) were also included in title III of TEFRA to raise sufficient revenue to fund the airport and airway spending authorized in title V of the Act. The various aviation excise taxes were extended and reinstated, some at higher tax rates, for the period September 1, 1982, through December 31, 1987 (see following table). Three modifications were made in the passenger ticket tax and an exemption was provided from the fuel and ticket taxes for helicopters used in timber operations or hard mineral exploration or development where the Federal aviation system and Federal-aid airports are not utilized. The Airport and Airway Trust Fund was extended through fiscal year 1987 and its expenditure purposes were updated to include the changes made in title V. (Adjustments in certain of the airport and airway spending programs were subsequently made in H.R. 6211 (P.L. 97-424), and conforming cross references in the Trust Fund provisions were also included.) The Trust Fund provisions were also transferred to the Internal Revenue Code, effective September 1, 1982.

1984 Amendment

The Deficit Reduction Act of 1984 (Public Law 98-369) expanded the previous exemptions from the aircraft fuels and air transportation taxes for helicopters not using federally aided airports or Federal airway facilities to include helicopters employed in the exploration and development of oil and gas (effective on April 1, 1984).

1987 Amendment

The Airport and Airway Safety and Capacity Expansion Act of 1987 (Public Law 100-223) contains as a separate revenue title for the purpose of funding, a 5-year Trust Fund spending authorization with extension of related excise taxes. The bill as passed extends for 3 years the present law airport and airway-related excise taxes and exemptions (January 1, 1988 through December 31, 1990) and extends for 5 years authority to spend from the Airport and Airway Trust Fund (October 1, 1987 through October 1, 1992). It provides for an automatic 50 percent reduction in air passenger ticket, cargo and fuel taxes for 1990, if Trust Fund appropriations for airport improvements, airway facilities and equipment, and research, engineering, and development for the prior 2 fiscal years total less than 85 percent of authorized levels. It also provides that emergency medical helicopters owned or leased by health care facilities which do not use the federally assisted airport and airway facilities funded by these taxes will be exempt from all applicable airport and airway excise taxes.

FINANCING MECHANISM

The Airport and Airway Trust Fund is financed by several aviation excise taxes. Generally these taxes are the same as in effect before October 1, 1980, except that the aviation fuel taxes are now at higher rates. The following table sets forth the taxes and rates under prior law and those presently in effect:

TABLE 1.—SCHEDULE OF AIRPORT AND AIRWAY TRUST FUND EXCISE TAXES

Tax (and code section)	Present law rate
Air passenger ticket tax (sec. 4261 (a), (b) and (d)) [1] [2]	8 percent.
Domestic air cargo tax (sec. 4271)	5 percent.
International departure tax (sec. 4261(c))	$3 per person.
Fuels tax for noncommercial (general) aviation (sec. 4041(c)) [2]	12 cents per gallon on gasoline; 14 cents per gallon on other fuels.
Aircraft tires tax (sec. 4071)	4.875 cents per pound.[3]
Aircraft tubes tax (sec. 4071)	10 cents per pound.[3]

[1] Air transportation between the United States and a foreign station which is not more than 225 miles from the nearest point in the continental United States, as well as between two such foreign stations, generally is subject to this tax where payment for the travel is made in the United States. The 1982 amendments permit the Secretary to waive the 225-mile zone rule if Canada or Mexico enter into a "qualified agreement". This tax does not apply to transportation between the United States and other foreign stations where payment is made outside the United States, nor does it apply to the U.S. portions of certain uninterrupted international air transportation (where the layover does not exceed 12 hours). Also, the air passenger ticket tax does not apply to the portion of flights to or from Alaska and Hawaii which are not made over the United States (Code sec. 4262).

[2] The tax does not apply to aircraft owned by a tax-exempt museum operated exclusively for the procurement, care, and exhibition of World War II aircraft (defined in sec. 4041(h)). Certain helicopters are exempt under the 1982, 1984, and 1987 amendments.

[3] Under the provisions of H.R. 6211 (PL 97–424), the taxes on inner tubes and non-highway tires were repealed, effective Jan. 1, 1984.

The passenger ticket tax applies to air passenger transportation within the United States, while the $3 per passenger international departure tax applies to flights abroad beginning in the United States and to flights to and from Alaska and Hawaii. The domestic air cargo tax applies to the transportation of property by air which begins and ends in the United States. Aircraft not subject to these passenger or freight taxes are subject to the fuel taxes noted above; exemptions are provided for aviation fuels used on farms or used for farming purposes or by a State or local government or a nonprofit educational organization. Also, under the 1982, 1984, and 1987 Acts, certain helicopters are exempt from the fuels and ticket taxes if used in timber or hard mineral operations or oil and gas exploration or development or emergency medical helicopters where the Federal aviation system and Federal-aid airports are not used.

EXPENDITURE PURPOSES

The present Trust Fund statute authorizes obligations incurred under Title I of the 1970 Act, under the 1976 Act Amendments, under the 1979 Act Amendments, under the Fiscal Year 1981 Authorization Act, under the Airport and Airway Improvement Act of 1982, or under the Airport and Airway Safety and Capacity Expansion Act of 1987, as such Acts were in effect on the date of enactment of the 1987 Act.

The Airport and Airway Trust Fund expenditure programs authorized under present law are generally as follows:

1. *Airport Development Aid Program (ADAP)*—

   (a) *Airport planning*—Grants to planning agencies for airport system planning and public agencies for airport master planning; also, airport noise compatibility planning grants for air carrier airports eligible for terminal development costs.

   (b) *Airport construction*—Construction, improvement or repair of a public airport (includes removal of airport hazards and construction of physical barriers and landscaping to diminish noise).

   (c) *Airport terminal facilities*—Non-revenue-producing public-use areas which are directly related to movement of passengers and baggage at certificated air carrier airports having required safety and security equipment (include baggage facilities and passenger-moving equipment); does not include costs of construction of public parking facility for passenger automobiles or costs of construction, alteration, or repair of a hangar or any airport building unless used to house facilities or activities directly related to safety of persons at the airport. These facilities include multimodal terminal development and bond retirement for certain airports.

   (d) *Land acquisition*—Includes land or property interests for airport noise control purposes.

   (e) *Airport-related equipment*—Airport security equipment required by DOT regulations, snow removal equipment, noise suppressing equipment, navigation aids, and safety equipment required for airport certification.

   (f) *Airport noise compatibility programs*—Includes soundproofing of public buildings; local governmental units are eligible for project grants as well as airports.

2. *Facilities and Equipment Program (F&E)*—Costs of acquiring, establishing, and improving air navigation facilities.

3. *Research, Engineering, Development, and Demonstration Program (R&D)*—Projects in connection with FAA research and development activities.

4. *Operations and Maintenance Programs (O&M)*—Flight check and maintenance of air navigation facilities; services provided under international agreements relating to the U.S. share of joint provision of air navigation services.

5. *Other costs*—Certain airline costs of international passenger security screening facilities.

MISCELLANEOUS

The Secretary of the Treasury is required to report to the Congress each year on the financial condition of the Trust Fund.

The Committee on Public Works and Transportation has jurisdiction over airport and airway development and improvement programs.

The statutory provisions establishing the Airport and Airway Trust Fund and governing its operations are located at section 9502 of the Internal Revenue Code.

FINANCIAL STATUS OF TRUST FUND

Table 2 is based on the Department of the Treasury's Annual reports on the Trust Fund and the Appendix to the U.S. Budget for fiscal years 1979–1989, and it sets forth the Fund's receipts and outlays for fiscal years 1971 through 1989.

Table 2 also contains cash balances in the Trust Fund at the end of each fiscal year since 1971. However, it must be noted that large portions of the unexpended balance are committed to liquidate outstanding unfunded obligations and unexpended appropriations. Table 3 sets forth the balances remaining in the Fund after these commitments have been taken into account, called the uncommitted balances, for fiscal years 1977 through 1989.

TABLE 2.—STATUS OF AIRPORT AND AIRWAY TRUST FUND, FISCAL YEARS 1971 THROUGH 1989

[In millions of dollars]

Fiscal year	Receipts				Outlays	Cash balance in the fund [2]
	Excise taxes, net	Interest on investments	Other [1]	Total		
1971	563		621	1,184	287	897
1972	649		902	1,551	1,389	1,058
1973	758		69	828	699	1,187
1974	840	28		868	521	1,534
1975	962	96		1,058	579	2,013
1976	938	146		1,084	547	2,550
T.Q	277	1		278	92	2,736
1977	1,191	194		1,384	853	3,268
1978	1,326	219		1,545	1,115	3,698
1979	1,526	282		1,809	1,114	4,392
1980	1,874	400		2,274	1,224	5,442
1981	21	561		582	1,306	4,719
1982	133	542		674	1,512	3,882
1983	2,165	533		2,698	1,792	4,787
1984	2,499	546		3,045	1,392	6,441
1985	2,852	746		3,598	2,613	7,426
1986	2,735	829		3,564	2,365	8,625
1987	3,060	880		3,940	2,631	9,935
1988 (estimate)	3,381	857		4,238	3,007	11,167

TABLE 2.—STATUS OF AIRPORT AND AIRWAY TRUST FUND, FISCAL YEARS 1971 THROUGH 1989—Continued

[In millions of dollars]

Fiscal year	Receipts				Outlays	Cash balance in the fund [2]
	Excise taxes, net	Interest on investments	Other [1]	Total		
1989 (estimate)	3,554	921	....	4,580	3,858	11,888

[1] Amounts appropriated from the general fund and unexpended balances of certain general fund accounts transferred to the Trust Fund.

[2] Large portions of the unexpended balance are committed to liquidate outstanding unfunded obligations (contract authority) and to liquidate unexpended appropriations. Also, funds equivalent to cumulative shortfalls below minimum annual obligation levels must be reserved for future expenditure.

Source: Appendix to the U.S. Budget for Fiscal Year 1989.

TABLE 3.—AIRPORT AND AIRWAY TRUST FUND UNCOMMITTED BALANCES—FISCAL YEARS 1977 THROUGH 1989

Uncommitted balance end of fiscal year	Millions of dollars
1977	1,709
1978	2,182
1979	2,742
1980	3,686
1981	3,021
1982	2,156
1983	1,882
1984	2,234
1985	2,039
1986	4,312
1987	5,559
1988 (estimate)	5,980
1989 (estimate)	5,596

Source: Appendix to the U.S. Budget for Fiscal Year 1989.

Section 3. Highway Trust Fund

LEGISLATIVE HISTORY

Development of the Trust Fund and Highway Tax Revenue Sources

The Highway Trust Fund was established in 1956 (Public Law 84-627) for a 16-year period to provide a specific source of financing for the new Interstate System and continuation of other Federal aid-highway programs. The other highway-aid programs previously had been financed through the general fund. The 1956 legislation increased certain highway user taxes, primarily the taxes on motor fuels (from 2 cents a gallon to 3 cents a gallon), and imposed a new highway user tax on heavy highway motor vehicles. Initially, the Trust Fund was financed by the proceeds of the following highway user excise taxes: the manufacturers' taxes on gasoline for highway use, and tires, tubes, and tread rubber for highway use; a portion of the manufacturers' tax on trucks and buses (20 percent for 1957 and 50 percent thereafter, until changed to 100 percent by 1961 legislation); the tax on use of heavy highway motor vehicles; and the retailers' tax on diesel and special motor fuels for highway use.[1]

Section 209(b) of the Highway Revenue Act of 1956 included a declaration of congressional policy that (1) if it appears that the total receipts of the Trust Fund will be less than the total expenditures from the Trust Fund, or (2) if it appears that the distribution of the tax burden among the various classes of highway users or other beneficiaries of the highways is not equitable, then Congress is to enact legislation to bring about a balance of total Trust Fund receipts and expenditures or to make an equitable distribution of the tax burden. In addition, the 1956 Act provided for a 3-year highway cost allocation study (later extended for 2 additional years) to determine the fair distribution of highway-related user taxes among the various users.

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[1] The Airport and Airway Revenue Act of 1970 created the Airport and Airway Trust Fund and deposited into it the manufacturers' and retailers' taxes on aviation gasoline, the manufacturers' taxes on tires and tubes of the types used on aircraft, and the retailers' taxes on aviation fuel, as well as the taxes on transportation of persons and property by air and on use of civil aircraft.

The Land and Water Conservation Act of 1965 created the Land and Water Conservation Fund and required that the taxes on special fuels and gasoline used as motorboat fuel be transferred to that fund from the Highway Trust Fund. In addition, P.L. 96-451 authorized transfers up to $20 million per year for fiscal year 1981-1983 of revenues from the motorboat fuel taxes to the National Recreational Boating Safety and Facilities Improvement Fund. This amount was increased to $45 million in the Highway Revenue Act of 1982. Deficit Reduction Act of 1984 made the fund a separate account (Boating Safety Account) within the Aquatic Resources Trust Fund.

The manufacturers' excise taxes on lubricating oil for highway use and truck and bus parts were transferred into the Trust Fund as the result of 1966 legislation.

The Revenue Act of 1971 repealed the tax on trucks and buses with gross vehicle weight of 10,000 pounds or less.

The Energy Act of 1978 repealed the manufacturers' tax on buses as well as the excise taxes on bus parts, tires and tubes, tread rubber and lubricating oil.

Section 209(g) of the Highway Revenue Act of 1956 also contained a provision—the "Byrd Amendment"—to prevent the Trust Fund from reaching a deficit position. In general, this provision required that if Trust Fund balances and estimated future receipts would be inadequate to cover obligations as they become due, a reduction of the Interstate System authorization in an amount sufficient to eliminate the difference would be required.

In 1959, the tax on motor fuels was temporarily increased for 1960 and 1961 from 3 cents a gallon to 4 cents a gallon in order to finance the authorized level of Trust Fund spending. The 4-cent rate was then extended in 1961 for the life of the Trust Fund (June 30, 1972, at that time). The 1961 legislation also increased the tax rates on tires, tubes and tread rubber, doubled the tax on heavy trucks, and transferred the entire 10-percent excise tax on trucks and buses to the Trust Fund (previously, only one-half of this tax went into the Trust Fund).[2] In addition, the 1961 Act extended the Highway Trust Fund for 3 months, from June 30, 1972, to September 30, 1972, again to provide additional revenues to meet projected highway program costs.

Highway legislation in 1966 also transferred the revenues from the existing manufacturers' excise taxes on lubricating oil and truck and bus parts to the Highway Trust Fund. Thus, with respect to the highway-related excise taxes, only the tax on automobiles did not go into the Trust Fund. (The 7-percent excise tax on automobiles was later repealed by the Revenue Act of 1971.)

Subsequent Extensions of Highway Trust Fund

The Highway Trust Fund and the related highway user taxes have been extended four times since 1961: a 5-year extension in the Federal-Aid Highway Act of 1970 (from September 30, 1972, through September 30, 1977), a 2-year extension in the Federal-Aid Highway Act of 1976 (through September 30, 1979), a 5-year extension in the Surface Transportation Assistance Act of 1978 (through September 30, 1984), a 4-year extension in the Surface Transportation Assistance Act of 1982 (through September 30, 1988), and a 5-year extension in the Surface Transportation and Uniform Relocation Assistance Act of 1987. The extensions, prior to 1982, were added by the Committee on Ways and Means as a separate title to a highway authorization bill of the Committee on Public Works and Transportation and involved only the extensions of existing highway user excise taxes and tax rates. (See reference to 1982 Act below).

In the 1978 Act, the operation of the "Byrd Amendment" was modified to require that when anticipated revenues are insufficient to cover expenditures, reductions will be made on a pro rata basis to all apportioned highway funds, rather than to interstate apportionments only (sec. 209(g) of the Highway Revenue Act of 1956). In addition, an exemption from the fuels taxes was provided for fuels used by qualified taxicabs, until the end of 1980 (later extended as a 4-cents-per-gallon exemption until October 1, 1985 and further extended through September 30, 1988 by the Tax Reform Act of

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[2] The 1961 Act also repealed a scheduled transfer to the Trust Fund of one-half the 10-percent excise tax on automobiles.

1986). Finally, two studies were required: a cost allocation study was required to be conducted by the Department of Transportation with a final report to Congress by January 15, 1982, and a study of the highway excise tax structure was required to be conducted by the Department of Treasury with a final report to Congress by April 15, 1982.[3]

Highway Revenue Act of 1982

The highway user tax and trust fund provisions were substantially revised in the Surface Transportation Assistance Act of 1982 (H.R. 6211), Public Law 97-424. Titles I and II of the Act contained authorizations for highway programs at higher levels for four fiscal years, 1983 through 1986. Accordingly, Title V, the Highway Revenue Act of 1982, extended and revised the highway user taxes and the Trust Fund for an additional 4 years, through September 30, 1988 (See following table). Those taxes and the Trust Fund are terminated on October 1, 1988.

In revising and extending the Highway Trust Fund, its provisions were codified in the Internal Revenue Code (section 9503), effective January 1, 1983. Eligible Trust Fund expenditure purposes were revised to include spending authorized under the 1982 Act. Further, the anti-deficit provision ("Byrd amendment") was revised to reduce apportionments when unfunded authorizations exceed estimated receipts for the following 24-month period. Trust Fund estimates are required quarterly.

The 1982 Act increased the amount of revenue (from the motorboat fuels taxes) that can be transferred to the Boating Safety Fund from $20 million to $45 million per year. This fund was also extended through fiscal year 1988.

The Act established a new Mass Transit Account, within the Highway Trust Fund, financed from the revenue equivalent of 1 cent of the 9 cents per gallon tax on fuels. Amounts in the Mass Transit Account are available for making capital expenditures authorized under section 21(a)(2) of the Urban Mass Transportation Act. An anti-deficit provision similar to that described above for the Highway Trust Fund, also is to be applied except that unfunded authorizations may not exceed estimated receipts for the following 12 months.

Deficit Reduction Act of 1984

The Deficit Reduction Act of 1984 (Public Law 98-369) revised several of the specific taxes imposed under the 1982 Act. These modifications are noted in the footnotes to table 1.

Surface Transportation and Uniform Relocation Assistance Act of 1987

The Surface Transportation and Uniform Relocation Assistance Act of 1987 (Public Law 100-17) extended highway-related excise taxes and exemptions through September 30, 1993, and authority to spend from the Highway Trust Fund through September 30, 1993.

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[3] The 1978 amendments were contained in Title V, the Highway Revenue Act of 1978, of the 1978 Surface Transportation Assistance Act (P.L. 95-599). The highway cost allocation study was submitted in May 1982 and the highway excise tax structure study was submitted in December 1982.

FINANCING MECHANISM

The highway excise taxes deposited into the Highway Trust Fund, as revised under the 1982 and 1984 Acts and in effect until October 1 1993, are set forth in the following table. Special effective dates are set forth in the footnotes.

TABLE 1.—HIGHWAY EXCISE TAX RATES UNDER PRESENT LAW

Tax	Present rate*
Gasoline (manufacturers)	9 cents per gallon.[1]
Diesel fuel (retail)	15 cents per gallon.[2]
Special motor fuels	9 cents per gallon.[1]
Methanol, ethanol fuels: [3]	
Fuels from other than petroleum or natural gas.	3 cents per gallon.[4]
Fuels from natural gas	4.5 cents per gallon.
Gasohol	3 cents per gallon.
Diesohol	9 cents per gallon.
Trucks and trailers (manufacturers) retail	12 percent of retail sale price.[5]
Truck parts and accessories (manufacturers)	No tax.[6]
Tires (manufacturers)	Graduated rates on highway tires over 40 pounds; no tax on other tires.[7]
Annual use tax on heavy trucks	55,000-up $100 plus $22 per 1,000 pounds in excess of 55,000 (maximum $550).[8]

*These excise taxes expire on Oct. 1, 1993.

[1] Effective April 1, 1983.

[2] The 1984 Act increased the tax from 9 cents per gallon to 15 cents per gallon, effective July 1, 1984. Owners of vehicles with a gross vehicle weight of 10,000 pounds or less are allowed an advanced rebate equal to an average estimated extra tax (above 9 cents per gallon) to be paid over the life of the vehicle.

[3] Alcohol fuels the content of which is at least 85 percent of methanol, ethanol or other alcohol.

[4] The additional 0.1 cent per gallon tax imposed under section 4041(d) for the Leaking Underground Storage Tank Trust Fund is 0.05 cents per gallon for such methanol and ethanol fuel.

[5] Under the 1982 Act, this tax will not apply to trucks under 33,000 pounds or trailers under 26,000 pounds, effective Jan. 7, 1983. Roadrailer trailers are exempt from the tax under the 1982 Act. The tax is reduced to 6 percent in the case of piggyback trailers and semitrailers sold from July 18, 1984, through July 17, 1985. The rate increase on trucks and trailers subject to the tax and the shift to the retail level are effective Apr. 1, 1983.

[6] Effective January 7, 1983.

[7] Effective Jan. 1, 1984, the 1982 Act repealed the taxes on inner tubes, tread rubber, and all tires other than highway tires weighing over 40 pounds. The tax on these highway tires is 15 cents per pound in excess of 40 pounds for tires between 40 and 70 pounds; $4.50 plus 30 cents per pound on the excess from 70 to 90 pounds; and $10.50 plus 50 cents per pound on the excess over 90 pounds.

[8] Effective July 1, 1984. The 1982 Act would have converted the tax to a graduated rate schedule based on taxable gross weight. However, the 1984 Act reduced the heavy vehicle use tax and increased the diesel fuel tax. The tax rate is reduced by 25 percent for logging vehicles that are used exclusively to haul harvested forested products to and from the forested site and are required to be registered for that purpose. An exemption is provided for vehicles which are used on the highways for 5,000 miles or less during the year. The exemption is increased to 7,500 miles for State-registered agricultural vehicles which haul farm commodities to or from the farm. The tax is prorated where vehicles are destroyed or stolen during the year. The tax is also prorated when the vehicle is initially placed in service after the first month of the taxable year.

Source: U.S. Budget Appendix, Fiscal Year 1989.

Under present law, exemptions from the fuels taxes are provided for fuel used on a farm or for farming purposes, and fuel used in intercity, local or school buses. An exemption of 4 cents per gallon of the tax on fuel used by qualified taxicabs is provided through September 30, 1988.[4] The 1982 Act also provided a full exemption for off-highway business use and for certain alcohol fuels. The exemption for gasohol was increased from 4 cents to 5 cents per gallon under the 1982 Act, and to 6 cents per gallon under the 1984 Act, effective from January 1, 1985, through December 31, 1992. In addition, buses are exempt from the 12-percent tax on trucks and trailers, and intercity, local and school buses are exempt from the taxes on tires, tubes, and tread rubber.[5] General exemptions are provided from these excise taxes for State and local governments and tax-exempt educational organizations. A 6 cents per gallon exemption from the excise tax on special motor fuels is provided through 1992 for neat methanol and ethanol fuels which are not derived from petroleum or natural gas.[6] A 4½ cents exemption is provided if the fuels are derived from natural gas. Neat alcohol fuels are at least 85 percent methanol, ethanol and other alcohol. All exemptions (except gasohol) will terminate when the taxes expire on October 1, 1993.

EXPENDITURE PURPOSES

Highway related programs

The statutory provisions governing expenditures from the Highway Trust Fund were revised in the 1982 Act to provide that amounts in the Trust Fund are to be available through September 30, 1993, as provided in appropriation acts, for meeting obligations incurred which are authorized by law to be paid out of the Trust Fund under the Highway Revenue Act of 1956, under Title I or II of the Surface Transportation Assistance Act of 1982, or thereafter, amounts for a general purpose authorized under these Acts as of December 31, 1982. As a result, the Trust Fund expenditure purposes are quite broad and include funding for:

—Federal-aid highways, including the interstate system, primary and secondary systems, urban systems, forest and public lands highways, scenic highways, overseas highways, etc.;
—Interstate resurfacing and repair;
—Bridge replacement;
—Highway safety research and development;
—Highway-related safety grants;
—Traffic control demonstration grants;
—Traffic control signal demonstration projects;

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[4] Under the 1982 Act, the fuel tax exemption for qualified taxicabs was extended from December 31, 1982 to September 30, 1984, and certain taxicabs were made eligible for the exemption for 1983 only (e.g., taxicabs prevented by local law from offering ridesharing). The 1984 Act extended the exemption through September 30, 1985. The Tax Reform Act of 1986 extended the exemption through Sept. 30, 1988.

[5] These exemptions for buses were adopted in the Energy Act of 1978 (Public Law 95–618) and extended in the 1982 Act. As noted earlier, the taxes on inner tubes and tread rubber are repealed effective January 1, 1984.

[6] The Tax Reform Act of 1986 reduced the 9-cents-per-gallon exemption to 6 cents per gallon effective for sales or use after December 31, 1986.

- —Intermodal urban demonstration projects and mass transit grants;
- —Carpools and vanpools grants;
- —National Highway Traffic Safety Administration for a share of traffic safety programs;
- —Certain administrative costs of FHWA and NHTSA; and
- —University transportation research centers.

Mass Transit Account

The 1982 Act established a new Mass Transit Account within the Highway Trust Fund, consisting of the revenue equivalent to 1 cent per gallon of the tax on fuels and interest earnings on amounts in the account. Amounts are available through September 30, 1993, as provided in appropriation acts, for making capital expenditures under section 21(a)(2) of the Urban Mass Transportation Act of 1964 (including new projects).

Transfers to the Land and Water Conservation Fund and Boating Safety Account of the Aquatic Resources Trust Fund

Revenues equivalent to the 9 cents per gallon tax on fuels used in motorboats are transferred to these two funds through fiscal year 1993: up to $45 million per year is to be transferred to the Boating Safety Account so long as the fund balance does not exceed $45 million, with the balance (not to exceed $1 million per fiscal year) to the Land and Water Conservation Fund. (See separate discussion of these funds in sections 4 and 7 following.)

MISCELLANEOUS

The Secretary of the Treasury is required to report to the Congress each year on the financial condition of the Trust Fund. In addition, the Deficit Reduction Act of 1984 directs the Secretary of Transportation, in consultation with the Secretary of the Treasury, to conduct studies of the highway use tax and to report to the Congress by October 1, 1987. The studies relate to (1) whether vehicles of 80,000 pounds or more bear their fair share of the costs of the highway system, (2) the significance of the use tax for trans-border trucking operations, and (3) the feasibility of weight-distance truck taxes. The 1984 Act directs the Secretary of the Treasury to conduct a study of the effectiveness of the partial tax exemption for fuels used in qualified taxicabs and to report to the Congress with recommendations by January 2, 1985. In addition, the 1984 Act requires the Secretary of Transportation to report to the Congress by May 2, 1985, on the appropriate application and level of the excise tax on piggyback trailers, which was received on August 20, 1987. The other reports have not been received at the time of publication of this document.

The Committee on Public Works and Transportation has jurisdiction over the highway and mass transit spending programs.

The statutory provisions establishing the Trust Fund and governing its operations are located at section 9503 of the Internal Revenue Code.

FINANCIAL STATUS OF TRUST FUND

Table 2 shows the current status of the Fund. The table is based on the Budget of the U.S. Government for Fiscal Year 1989.

HIGHWAY TRUST FUND

[In thousand of dollars]

	1987	1988 estimate	1989 estimate
Unexpended balance, start of year	12,772,866	13,607,039	14,893,765
Cash income:			
Receipts	13,032,356	14,332,000	14,298,000
Interest on investment	1,277,765	1,173,600	1,228,700
Total annual income	14,310,121	15,505,600	15,526,700
(Mass transit account)	(1,582,713)	(1,581,400)	(1,691,000)
Cash outlays:			
Federal Highway Administration	12,641,503	13,290,910	13,347,765
National Highway Traffic Safety Administration	148,139	155,618	159,576
Urban Mass Transportation Administration	667,534	753,275	1,175,705
Other	18,771	19,071	22,400
Total	13,475,947	14,218,874	14,705,446
Balance of fund, end of year	13,607,039	14,893,765	15,715,019
Commitment against unexpended balances	−34,063,382	−35,128,766	−35,746,663
Uncommitted balance, end of year	−20,456,343	−20,235,001	−20,031,644

Source: U.S. Budget Appendix, Fiscal Year 1989.

Section 4. Aquatic Resources Trust Fund ("Wallop-Breaux" Fund)

LEGISLATIVE HISTORY

Current Law

The Deficit Reduction Act of 1984 (Public Law 98–369) established a new trust fund, the Aquatic Resources Trust Fund (known as the Wallop-Breaux Fund), by combining and expanding the prior fish restoration and management projects ("Dingell-Johnson" Fund) and the prior National Recreation Boating Safety and Facilities Improvement Fund ("Biaggi" Fund) into a single Trust Fund. The Trust Fund consists of two accounts, the Sport Fish Restoration Account and the Boating Safety Account.

Prior Law

Fish restoration

The Act of August 9, 1950 (commonly referred to as the Dingell-Johnson Act), provided for cooperation between the Federal Government and State fish and game departments. Although the Act did not establish a trust fund, appropriations were linked to specific tax revenues. Limits were placed on State expenditures of federally-appropriated funds until the State had passed laws governing the conservation of fish and the State met other requirements.

Boating safety

1980 Act.—The National Recreational Boating Safety and Facilities Improvement Fund was enacted on October 14, 1980 (Public Law 96–451). Before this time, all funds attributable to the excise taxes on motorboat use of gasoline and other motor fuels were transferred periodically from the Highway Trust Fund into the Land and Water Conservation Fund. The 1980 Act provided financing for the Boating Fund for fiscal years 1981 through 1983.

1982 Act.—The Highway Revenue Act of 1982 (title V of the Surface Transportation Assistance Act of 1982; Public Law 97–424) extended the Boating Fund through fiscal year 1988, and increased the amounts to be transferred into the Fund.

1987 Act.—The Surface Transportation and Uniform Relocation Assistance Act of 1987 extended the Boating Fund through fiscal year 1993.

FINANCING MECHANISM

Amounts equivalent to the following revenues are appropriated into the Aquatic Resources Trust Fund:

(1) Revenues from the excise tax on sport fishing equipment, electric outboard motors and sonar devices suitable for finding fish under Internal Revenue Code section 4161;

(2) Revenues from the 9-cents-per-gallon excise tax on gasoline and special motor fuels in motorboats (other than $1 million of those revenues which will continue to be transferred to the Land and Water Conservation Fund); and

(3) Import duties imposed on fishing equipment and on yachts and pleasure craft.

The revenues from the motorboat fuels excise tax described above is allocated first to the Land and Water Conservation Fund (up to $1 million annually) and second to the Boating Safety Account (up to a maximum of $45 million for each fiscal year through 1993). In addition, the maximum amount permitted to be held by the account at any time cannot exceed $45 million.

All the remaining revenues described above are allocated to the Sport Fish Restoration Account.

EXPENDITURE PURPOSES

Sport Fish Restoration Account

Moneys in the account may be expended, subject to appropriation acts,[1] for the purpose of restoring and managing all species of fish that have material value in connection with sport or recreation in the marine and/or fresh waters of the United States, including:

(1) Such research into problems of fish management and culture as may be necessary for efficient administration of fish resources;

(2) Acquisition of such information as necessary to guide and direct the regulation of fishing by law, including the extent of the fish population, the drain on the fish supply from fishing and/or natural causes, the necessity of legal regulation of fishing, and the effects of any measures of regulation that are applied;

(3) Formulation and adoption of plans for restocking waters with food and game fish according to natural areas or districts to which such plans are applicable, together with the acquisition of such facts as are necessary to the formulation, execution, and testing of such plans;

(4) Selection and improvement of areas of water or land adaptable as hatching, feeding, or breeding places for fish, including acquisition by purchase, condemnation, lease, or gift of such areas as are suitable therefore, and the construction thereon of such improvements, as may be necessary to make them available for these purposes;

(5) Acquisition, development, renovation, or improvement of facilities (and auxiliary facilities necessary to ensure safe use of such facilities) that create, or add to, public access to the waters of the United States for boating purposes;

(6) Aquatic resources education programs for increasing public understanding of the Nation's water resources and associated aquatic life forms; and

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[1] The permanent appropriations provision under the Act of August 31, 1951, is retained by the 1984 Act and governs expenditures from the Sport Fish Restoration Account, as successor to the sport fish restoration program of prior law.

(7) Subject to a percentage limitation contained in the 1984 Act, for administration of the sport fish restoration program by the Secretary of the Interior.

Moneys in the Account remain available until spent.

Boating Safety Account

Moneys in the Boating Safety Account may be expended, subject to appropriation Acts, as follows:

(1) Two-thirds of the amount allocated to the Account in any fiscal year for State boating safety programs (i.e., up to $30 million); and

(2) One-third of the amount allocated to the Account in any fiscal year for the operating expenses account of the Coast Guard (including the Coast Guard Auxiliary) to defray the cost of services provided by it for recreational boating safety (i.e., up to $15 million).

The State boating safety programs purposes eligible for funding from the account are:

(1) Providing facilities, equipment, and supplies for boating safety education and law enforcement, including purchase, operation, maintenance, and repair;

(2) Training personnel in skills related to boating safety and to the enforcement of boating safety laws and regulations;

(3) Providing public boating safety education, including education programs and lectures, to the boating community and the public school system;

(4) Acquiring, constructing, or repairing public access sites used primarily by recreational boaters;

(5) Conducting boating safety inspections and accident investigations;

(6) Establishing and maintaining facilities for emergency or search-and-rescue assistance; and

(7) Establishing and maintaining waterway markers and other appropriate aids to navigation.

Moneys in the Account will be available, subject to appropriations Acts, for expenditure by the Secretary of Transportation pursuant to that Secretary's contract authority, and will remain available until spent.

MISCELLANEOUS

Statutory language relating to sport fish restoration is located at 16 U.S.C. 777 and following. Statutory language relating to boat safety is located at 46 U.S.C. 2102 and 13101 and following. The Aquatic Resources Trust Fund is established by section 9504 of the Internal Revenue Code.

Jurisdiction over program aspects of the Aquatic Resources Trust Fund is in the Committee on Merchant Marine and Fisheries.

FINANCIAL STATUS OF THE TRUST FUND

The table below describes amounts in the Trust Fund that are available for appropriation.

AMOUNTS AVAILABLE FOR APPROPRIATIONS

[In thousands of dollars]

	1987 actual	1988 estimate	1989 estimate
Unappropriated balance, start of year	152,751	175,039	208,726
Collection (receipts):			
Excise taxes and duties	193,882	220,860	217,158
Interest on investments	18,002	19,000	20,000
Total available for appropriations	364,635	414,899	445,884
Appropriation			
National Park Service (Department of the Interior)	1,000	1,000	1,000
U.S. Coast Guard (Department of Transportation)	47,581	44,100	45,000
U.S. Fish and Wildlife Service (Department of the Interior):			
Sport fish restoration account	141,015	161,073	194,760
(Motorboat fuels tax)	(28,165)	(50,775)	(63,900)
(Excise tax on sport fishing equipment)	(67,979)	(77,032)	(90,417)
(Import duties on tackle and yachts)	(31,294)	(18,688)	(21,443)
(Interest)	(13,578)	(14,578)	(19,000)
Unappropriated balance, end of year	175,039	208,726	205,124

Source: U.S. Budget Appendix, fiscal year 1989.

Section 5. Harbor Maintenance Trust Fund

LEGISLATIVE HISTORY

The Harbor Maintenance Trust Fund was established by the Congress in the Harbor Maintenance Revenue Act of 1986 (Title XIV of the Water Resources Development Act of 1986, Public Law 99–662), effective April 1, 1987.

FINANCING MECHANISM

The 1986 Act imposed a new excise tax on the use of a U.S. harbor or channel ("port") by a commercial vessel for loading or unloading of commercial cargo, effective on April 1, 1987. The tax rate is 0.04 percent (4 cents per $100) on the value of the cargo (section 4461 of the Internal Revenue Code). Numerous special rules are included in section 4462 of the Internal Revenue Code. The tax is administered and enforced by the U.S. Customs Service.

The Trust Fund receives amounts equivalent to revenues from the harbor maintenance tax and revenues from the U.S. portion of Saint Lawrence Seaway tolls. In addition, the Trust Fund earns interest on investments of any cash balance.

EXPENDITURE PURPOSES

Amounts in the Trust Fund are available, as provided by appropriations Act, for making expenditures for:

(1) 100 percent of the eligible operations and maintenance costs of those portions of the Saint Lawrence Seaway operated and maintained by the Saint Lawrence Seaway Development Corporation for the fiscal year;

(2) not more than 40 percent of the eligible operations and maintenance costs assigned to commercial navigation of all harbors and inland harbors within the United States

(3) payments of rebates of tolls or charges of the U.S. portion of the Saint Lawrence Seaway to payors; and

(4) payment of all expenses of administration incurred by the Treasury Department in administering the harbor maintenance tax, not to exceed $5 million per fiscal year (if the customs user fee enacted in 1986 is repealed.).

The administration's Budget for Fiscal Year 1988 stated that legislation will be proposed to restore financing of the Saint Lawrence Seaway Development Corporation's operation and maintenance to the status prior to passage of the 1986 Act. Under such a proposal, the Corporation, would retain the tolls to finance operation and maintenance, and rebates would continue to be paid out of the Trust Fund.

MISCELLANEOUS

The 1986 Act required the Secretary of the Treasury, in consultation with the Secretaries of the Army and Transportation, the U.S. Trade Representative, and representatives of U.S. ports, to conduct a study to determine the impact of the port use tax on potential diversions of cargo to Canada and Mexico from U.S. ports. The Secretary's report was due to the Congress by November 17, 1987.This report had not been received at the time this document was published.

The 1986 Act also required the Secretary of State, in consultation with the Secretary of Transportation, to initiate discussions with Canada regarding reducing or eliminating all tolls on the Saint Lawrence Seaway and international Great Lakes. The Secretary is to report to the Congress on the progress of such discussions by November 17, 1988.

The statutory language establishing the Trust Fund is located in section 9505 of the Internal Revenue Code.

FINANCIAL STATUS OF FUND

The table below describes amounts in the Trust Fund that are available for appropriation.

HARBOR MAINTENANCE TRUST FUND

(In thousands of dollars)

	1987 actual	1988 estimate	1989 estimate
Unappropriated balance, start of year		16,333	3,091
Receipts:			
Revenue	57,643	153,585	–166,000
Interest on Investment	551	859	842
Total	58,194	154,444	166,842
Total available for appropriation	58,194	170,777	169,933
Total annual appropriation	–42,998	–167,686	–166,800
Unappropriated balance, end of year	16,333	3,091	3,133

Source: U.S. Budget Appendix, Fiscal Year 1989.

Section 6. Inland Waterways Trust Fund

LEGISLATIVE HISTORY

The Inland Waterways Trust Fund was established in Title II of Public Law 95-502, the Inland Waterways Revenue Act of 1978, enacted on October 21, 1978. The purpose of the Act is to provide funding for making construction and rehabilitation expenditures for navigation on specified inland and intracoastal waterways. The Harbor Maintenance Revenue Act, Title XIV of the Water Resources Development Act of 1986 (Public Law 99-662), increased the tax rate and added one new waterway.

FINANCING MECHANISM

The 1978 Act imposed an excise tax (section 4042 of the Internal Revenue Code) effective October 1, 1980, on fuel used by vessels in commercial waterway transportation on those 26 inland and intracoastal waterways specified in section 206 of the Act. These waterways include the Mississippi River upstream from Baton Rouge, the Mississippi's tributaries, and the Gulf and Atlantic Intracoastal Waterways. The 1986 Act added the Tennessee-Tombigbee Waterway to the list of inland waterways the use of which is subject to the fuel tax, effective January 1, 1987.

The tax rate was established in the 1978 Act at 4 cents per gallon for October 1, 1980, through September 30, 1981, with scheduled increases of 2 cents per gallon on October 1, 1981 (to 6 cents), October 1, 1983 (to 8 cents), and October 1, 1995 (to 10 cents). The 1986 Act provides scheduled increases in the inland waterways fuel tax to 11 cents per gallon on January 1, 1990, to 13 cents per gallon on January 1, 1991, to 15 cents per gallon on January 1, 1992, to 17 cents per gallon on January 1, 1993, to 19 cents per gallon on January 1, 1994, and to 20 cents per gallon on January 1, 1995, and thereafter. The tax does not apply to deep-draft ocean-going vessels, passenger or fishing vessels, or certain barges. The revenues from this tax are deposited into the Trust Fund. The Trust Fund also earns interest on investments of any cash balance.

EXPENDITURE PURPOSES

Amounts in the Trust Fund are available, as provided by appropriation Acts, for making construction and rehabilitation expenditures for navigation on the inland and coastal waterways of the United States described in section 206 of the Inland Waterways Revenue Act of 1978, as in effect on January 1, 1987 (the effective date of the 1986 Act provision). Not more than half of the cost of any construction to which section 102(a) of the 1986 Act applies may be paid from the Trust Fund. (Section 102(a) requires that half the costs of construction for certain listed projects be paid from amounts appropriated from the general fund of the Treasury.)

MISCELLANEOUS

The 1978 Act required an extensive study of inland waterways users taxes and charges by the Secretary of Transportation and the Secretary of Commerce, in consultation with a number of other agencies which was received by the Congress in February 1982.

The Secretary of the Treasury is also required to submit an annual report to the Congress on the financial condition of the Trust Fund, beginning September 30, 1981.

The House Committee on Public Works and Transportation has jurisdiction over inland waterway authorizations.

Statutory language relating to inland waterway expenditures is located at 33 U.S.C. 1801. The Inland Waterways Trust Fund is established by section 9506 of the Internal Revenue Code.

FINANCIAL STATUS OF THE TRUST FUND

The table below describes amounts in the Trust Fund that are available for appropriation.

AMOUNTS AVAILABLE FOR APPROPRIATION

[In thousands of dollars]

	1987 actual	1988 estimate	1989 estimate
Unappropriated balance, start of year	239,896	294,969	320,369
Receipts:			
Inland waterway fuel tax	48,334	49,100	49,800
Interest and profits on investments	30,926	14,300	13,400
Total available for appropriation	319,156	358,369	383,569
Appropriation	−26,000	−38,000	−77,467
Unappropriated balance, end of year	294,969	320,369	306,102

Source: U.S. Budget Appendix, Fiscal Year 1989.

Section 7. Hazardous Substance Superfund

LEGISLATIVE HISTORY

A Hazardous Substance Response Trust Fund was enacted in Title II, Subtitle B of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 on December 11, 1980 (Public Law 96-510). The taxes enacted to fund the Trust Fund expired on September 30, 1986.

The Trust Fund and related taxes (including additional taxes) were reestablished by the Superfund Revenue Act of 1986 (Title V of the Superfund Amendments and Reauthorization Act of 1986, Public Law 99-499).

The 1980 Act appropriated to the Trust Fund amounts equivalent to the excise taxes received by the Treasury under Internal Revenue Code sections 4611 and 4661, the amounts recovered on behalf of the Trust Fund under the Act, all moneys recovered or collected under section 311(b)(6)(B) of the Clean Water Act, penalties assessed under Title I of the 1980 Act, and punitive damages under section 107(c)(8) of the 1980 Act.

Section 4611 of the Internal Revenue Code imposed a tax of 0.79 cent per barrel on crude oil used in, exported from, or imported into the United States. Section 4661 of the Internal Revenue Code imposed a tax on any taxable chemical sold by a manufacturer, producer, or importer.

The 1980 Act also authorized to be appropriated to the Trust Fund $44 million in each fiscal year from 1981 through 1985. The 1980 Act provided for the transfer to the Trust Fund on one-half of the unobligated balance remaining on December 10, 1980, under the Fund in section 311 of the Clean Water Act and the amounts appropriated under section 504(b) of the Clean Water Act during any fiscal year.

When the 1986 Act reinstated the Trust Fund, its title was changed to the Hazardous Substance Superfund.

FINANCING MECHANISM

The 1986 Act provides for deposits into the Trust Fund of tax revenues and general revenue appropriations intended to total $8.5 billion in revenues for fiscal years 1986-1990 (including interest and estimated recoveries). The 1980 legislation had been designed to provide only $1.6 billion for the Trust Fund for fiscal years 1981-1985 ($0.2 billion from the petroleum tax, $1.2 billion from the feedstock chemicals tax, and $0.2 billion from general revenue appropriations). The 1986 Act would provide the $8.5 billion in estimated revenue in the following manner:

	Billions
Petroleum tax	$2.75
Feedstock chemicals tax	1.40
Environmental income tax	2.50
General revenue appropriations	1.25
Interest	.30
Recoveries	.30
Total	8.50

The specific financing provision are as follows:

1. Petroleum tax

The petroleum tax of prior law is reimposed (effective January 1, 1987) at a rate of 8.2 cents per barrel for domestic crude oil, and 11.7 cents per barrel for imported petroleum products (including imported crude oil). The petroleum tax generally expires on December 31, 1991. The tax would terminate earlier than that date if cumulative Superfund tax receipts during the reauthorization period equal or exceed $6.65 billion. Additionally, if (1) on December 31, 1989 or December 31, 1990, the unobligated balance of the Trust Fund exceeds $3.5 billion, and (2) the Secretary of the Treasury, in consultation with the EPA Administrator, determines that such unobligated balance will exceed $3.5 billion on December 31 of the next following calendar year if no Trust Fund taxes are imposed during that year, then no tax is to be imposed during that year.

2. Tax on feedstock chemicals

The 1986 Act reimposes the tax on feedstock chemicals at its prior law rates (except in the case of xylene). Under the 1986 Act, except for imports and exports, xylene does not include separated isomers for purposes of the tax. Taxes previously imposed on xylene are refunded or credited (with interest) to the taxpayers. To compensate for lost revenues, the tax rate on xylene is increased. The tax is effective on January 1, 1987. The tax would expire under the same circumstances as described for the petroleum tax.

An exemption for exported feedstock chemicals and certain derivatives is allowed.

3. Tax on imported chemical derivatives

A tax on certain imported chemical feedstock derivatives is imposed as though the taxable chemicals used as materials had been sold in the United States for an equivalent use. If the importer does not furnish information to make the above determination, the amount of the tax is 5 percent of the customs value of the imported chemical derivative.

4. Environmental income tax

The 1986 Act provides a new environmental tax based on corporate alternative minimum taxable income. The amount of tax is equal to 0.12 percent ($12 of tax per $10,000) of alternative minimum taxable income without regard to net operating losses and the deduction for this tax, over $2 million.

The environmental tax is effective for taxable years beginning after December 31, 1986. The environmental tax is not imposed in any taxable year beginning during a calendar year in which the petroleum and chemical feedstock taxes are not imposed.

EXPENDITURE PURPOSES

Amounts in the Trust Fund are available for expenditures, under appropriations Acts, incurred in connection with releases or threats of releases of hazardous substances into the environment. Allowable costs include (1) costs of responding to the presence of hazardous substances on land or in the water or air, including cleanup and removal of such substances and remedial action and (2) certain costs related to response including epidemiologic studies and maintenance of emergency strike forces. Payments for natural resource damage claims are not allowed (although they were allowed before the 1986 Act).

MISCELLANEOUS

A separate Trust Fund, the Post-Closure Liability Trust Fund, was created by the 1980 Act to assume completely the liability of owners and operators of hazardous waste disposal facilities that have been granted permits and have been properly closed under Subtitle C of the Resource Conservation and Recovery Act. The Post-Closure Fund was financed through a tax of $2.13 per dry weight ton on hazardous waste. The 1986 Act repealed the Post-Closure Fund and tax, effective October 1, 1983 (the original effective date of the tax). Taxpayers who paid the tax may file claims for refunds of the tax, plus interest. The statute of limitations is extended so that taxpayers who paid the tax may file claims for refunds.

The Hazardous Substance Superfund is established in section 9507 of the Internal Revenue Code. The Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA) is located at 42 U.S.C. 9601 et seq. The Energy and Commerce Committee has jurisdiction over CERCLA.

FINANCIAL STATUS OF FUND

The table below describes amounts in the Trust Fund that are available for appropriation.

AMOUNTS AVAILABLE FOR APPROPRIATION

[In thousands of dollars]

	1987 actual	1988 estimate	1989 estimate
Unappropriated balance, start of year	9,034		443,550
Receipts:			
Interest	16,856	72,400	92,000
Fines and recoveries	18,918	52,050	70,050
Transfers from the general fund, amounts equivalent to taxes	830,537	1,208,000	1,277,000
Payments and advances from the general fund	535,955	239,100	
Total:			
Available for appropriation	1,411,300	1,571,550	1,882,600
Appropriation	−1,411,300	−1,128,000	−1,600,000
Unappropriated balance, end of year		443,550	282,600

Source: U.S. Budget Appendix, Fiscal Year 1989.

Section 8. Leaking Underground Storage Tank Trust Fund

LEGISLATIVE HISTORY

The Superfund Revenue Act of 1986 (Title V of the Superfund Amendments and Reauthorization Act of 1986, Public Law 99–499) established in the Treasury the Leaking Underground Storage Tank Trust Fund, effective on January 1, 1987.

FINANCING MECHANISM

The 1986 Act imposed additional taxes on gasoline, diesel fuel, special motor fuels, fuels used in aviation, and fuels used in commercial transportation on inland waterways (sections 4081, 4041, 4042, etc. of the Internal Revenue Code). The additional excise tax of 0.1 cents per gallon terminates on the earlier of December 31, 1991, or when the net revenues from the tax are at least $500 million. Amounts equivalent to the taxes received in the Treasury are appropriated into the Trust Fund. In addition, amounts received in the Treasury and collected under section 9003(h)(6) of the Solid Waste Disposal Act are to be deposited into the Fund (recoveries from parties responsible for leaking tanks).

EXPENDITURE PURPOSES

Amounts in the Trust are available, as provided in appropriation Acts, to pay cleanup and related costs of the Environmental Protection Agency involving tanks where no solvent owners can be found, or where the owner or operator refuses or is unable to comply with an urgent corrective order. Trust Fund revenues are also available to provide grants to States for up to 90 percent of the costs of carrying out these purposes.

The Administration's Budget for fiscal year 1988 stated that the Environmental Protection Agency will develop and oversee the cleanup program which will be implemented by the States. Funds will be allocated to the States through cooperative agreements, to clean up those sites posing the greatest threat to human health and the environment. The Trust Fund will also cover administrative expenses necessary to carry out the program.

MISCELLANEOUS

The statutory provisions providing for cleanup of petroleum from leaking underground storage tanks is located at 42 U.S.C. 6991. The Energy and Commerce Committee has jurisdiction over program aspects of the cleanup of leaking underground storage tanks.

The Trust Fund is established in section 9508 of the Internal Revenue Code.

FINANCIAL STATUS OF THE TRUST FUND

The table below describes amounts in the Trust Fund that are available for appropriation.

AMOUNTS AVAILABLE FOR APPROPRIATION

[In thousands of dollars]

	1987 actual	1988 estimate	1989 estimate
Unappropriated balance, start of year		24,407	150,507
Receipts:			
Interest	1,407	10,500	17,700
Transfers from the general fund, amounts equivalent to taxes	73,000	130,000	131,000
Total:			
Available for appropriation	74,407	164,907	299,207
Appropriation	−50,000	−14,400	−50,000
Unappropriated balance, end of year	24,407	150,507	249,207

Source: U.S. Budget Appendix, Fiscal Year 1989.

Section 9. Oil Spill Liability Trust Fund

LEGISLATIVE HISTORY

The Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) establishes in the Treasury an Oil Spill Liability Trust Fund. The 1986 Act also imposes certain taxes on domestic and imported oil to provide revenue for the Trust Fund. The Oil Spill Fund provisions and the related taxes will be effective at the beginning of the first month occurring more than 30 days after enactment of authorizing legislation, but in no event will such provisions and taxes be effective before February 1, 1987. The taxes and Trust Fund provisions will never become effective if authorizing legislation is not enacted by September 1, 1987. At this time, authorizing legislation has not yet been enacted.

FINANCING MECHANISM

The Trust Fund would be financed in part by an excise tax of 1.3 cents per barrel on crude oil and imported petroleum products. The tax would be imposed on the same crude oil and petroleum products, and would be subject to the same definitional and other provisions as the Superfund petroleum tax (section 4611 of the Internal Revenue Code). A credit against the oil spill tax would be allowed for amounts paid by the taxpayer before 1987 into the Deepwater Port Fund or the Offshore Oil Fund (including the contributors' share of accrued interest on contributions determined as of January 1, 1987).

The excise tax on petroleum that is used to finance the Oil Spill Fund would terminate when cumulative revenues from the tax reach $300 million.

EXPENDITURE PURPOSES

The general expenditure purposes of the Trust Fund are limited to payments, as provided in appropriation Acts, of (1) certain removal costs and related costs associated with oil spills; (2) claims asserted under authorizing legislation substantially similar to the Comprehensive Oil Pollution Liability and Compensation Act (which was adopted by the House of Representatives during the 99th Congress); (3) administrative expenses incurred by the Federal Government under the authorizing legislation; and (4) contributions to the International Fund for Compensation for Oil Pollution Damage if the conventions establishing this fund come into force with respect to the United States.

MISCELLANEOUS

Statutory provisions providing for cleanup of oil spills in navigable waters had not been enacted upon publication of this document.

The Committee on Merchant Marine and Fisheries and the Committee on Public Works have jurisdiction over program aspects of the cleanup of oil spills in navigable waters.

The Trust Fund is established in section 9509 of the Internal Revenue Code.

Section 10. Land and Water Conservation Fund

LEGISLATIVE HISTORY

On September 3, 1964, the Congress enacted Public Law 88-578, which established the Land and Water Conservation Fund as a separate account in the Treasury, effective January 1, 1965. Minor amendments were made to the Fund in 1965 (Public Law 89-72).

In 1968, Public Law 90-401 eliminated the system of user fees for all Federal recreation areas that had been included previously in the law. The repeal was effective December 31, 1971.[1] The 1968 Act also added authorization for additional appropriations of such amounts as were necessary to make the income of the Fund not less than $200 million for each of the five fiscal years beginning July 1, 1968, and ending June 30, 1973. To the extent that appropriated sums were insufficient to reach the required amounts, an amount sufficient to cover the remainder was to be credited to the Fund from revenues due and payable to the United States for deposit in the Treasury as miscellaneous receipts under the Outer Continental Shelf Lands Act.

In 1970, Public Law 91-485 increased the authorized appropriations to not less than $300 million for fiscal years 1971 through June 30, 1989. As a result of amendments in 1976 and 1977, the amount for fiscal year 1978 was increased to $900 million (Public Law 94-422, Public Law 94-273 and Public Law 95-42).

In 1981, Public Law 96-451 provided for the transfer from the Land and Water Conservation Fund of an amount not to exceed $20 million per year for fiscal years 1981-1983 of revenues from motorboat fuel taxes to the National Recreational Boating Safety and Facilities Improvement Fund. The Highway Revenue Act of 1982 (Title V of the Surface Transportation Assistance Act of 1982, Public Law 97-424) increased this limitation on transfers of motorboat fuels taxes to the Boating Fund to $45 million through September 30, 1988. The Surface Transportation and Uniform Relocation Assistance Act of 1987 (Public Law 100-17) extended this transfer through 1993. In 1981, Public Law 96-514 provided that revenues from recreation fee collections should be deposited into the Land and Water Conservation Fund.

The Deficit Reduction Act of 1984 (Public Law 98-369) reduced the amount attributable to the excise taxes on gasoline and special fuels used in motorboats which is transferred to the Land and Water Conservation Fund. Under the Act, an amount not to exceed $1 million per fiscal year of the revenue attributable to these motorboat fuels excise taxes will continue to be transferred to the Fund. (See section 4 for changes in the Boating Fund.)

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[1] A limited system of fees was later reinstated, and for several years these revenues generally were to be collected into a special account in the Treasury to be administered in conjunction with, but separately from, the Land and Water Conservation Fund.

FINANCING MECHANISM

Internal Revenue Code section 9503 provides that up to $1 million per year of amounts equivalent to motorboat fuel taxes will be transferred from the Highway Trust Fund to the Land and Water Conservation Fund.

As provided by 16 U.S.C. 460*l*–5, the following amounts will be deposited in the Land and Water Conservation Fund:

(1) All proceeds (except that committed under 40 U.S.C. 485 (b) to (e) or the Independent Offices Appropriation Act or in any later appropriations act) received from any disposal of surplus real property and related personal property under the Federal Property and Administrative Services Act of 1949 (as amended), notwithstanding any provisions of law that such proceeds shall be credited to miscellaneous receipts of the Treasury;

(2) The motorboat fuel tax revenues described above (not including revenues from the 0.1 cents per gallon tax imposed to provide funds for cleanup of leaking underground storage tanks) and certain related revenues received before July 1, 1978;

(3) In addition, there are authorized to be appropriated annually to the Fund such amounts as necessary to make the income of the Fund not less than $300 million for fiscal year 1977, and $900 million for fiscal year 1978 and for each fiscal year thereafter through September 30, 1989; and

(4) To the extent that the appropriated sums are not sufficient to make the total annual income of the Fund equivalent to the amounts enumerated above, an amount sufficient to cover the remainder shall be credited to the Fund from revenues due and payable as miscellaneous receipts under the Outer Continental Shelf Lands Act (43 U.S.C. 1331 *et seq.*).

Moneys collected into the Fund under (4) above remain in the Fund until appropriated by the Congress.

16 U.S.C. 460*l*–5a provides that revenues from recreation fee collections by Federal agencies shall be paid into the Land and Water Conservation Fund, to be available for appropriation for any or all purposes authorized by the Land and Water Conservation Fund.

EXPENDITURE PURPOSES

16 U.S.C. 460*l*–4 provides that the land and water conservation provisions of section 460 are "to assist in preserving, developing, and assuring accessibility to all citizens of the United States of America of present and future generations and visitors who are lawfully present within the boundaries of the United States of America such quality and quantity of outdoor recreation resources as may be available and are necessary and desirable for individual active participation in such recreation and to strengthen the health and vitality of the citizens of the United States by (1) providing funds for and authorizing Federal assistance to the States in planning, acquisition, and development of needed land and water areas

and facilities and (2) providing funds for the Federal acquisition and development of certain lands and other areas."

Moneys in the Fund are available for expenditures as provided in appropriation acts. Not less than 40 percent of annual appropriations are to be used for Federal purposes; these include activities and programs of the Bureau of Land Management, the Forest Service, the Fish and Wildlife Service and the National Park Service. The remainder of funds appropriated are for State purposes, and these funds are apportioned among the States on the basis of statutory formula and criteria.

MISCELLANEOUS

Jurisdiction over the land and water conservation programs is within the Committee on Interior and Insular Affairs.

No annual report is required on the Fund's financial condition or operations.

The statutory provisions establishing the Land and Water Conservation Fund and governing its operation are located at 16 U.S.C. 460(l).

FINANCIAL STATUS OF FUND

The table below describes the amounts in the Trust Fund that are available for appropriation.

LAND AND WATER CONSERVATION FUND

[In thousands of dollars]

	1987 actual	1988 estimate	1989 estimate
Unappropriated balance, start of year	4,345,836	5,035,210	5,764,746
Receipts	900,000	900,000	900,000
Appropriations	−210,626	−170,464	−21,653
Unappropriated balance, end of year	5,035,210	5,764,746	6,643,093
Special account (Public Law 95-42, sec. 1):			
Unappropriated balance, start of year	142,621	142,621	142,621
Unappropriated balance, end of year	142,621	142,621	142,621

Source: U.S. Budget Appendix, Fiscal Year 1989.

Section 11. Wildlife Restoration Projects ("Pittman-Robertson" Fund)

LEGISLATIVE HISTORY

The Act of September 2, 1937, provided for cooperation between the Federal Government and the States regarding wildlife restoration projects. The 1939 Reorganization Plan No. II, section 4(f), transferred the functions of the Secretary of Agriculture relating to the conservation of wildlife game and migratory birds to the Secretary of the Interior.

The 1937 Act provided that amounts equivalent to excise taxes on sporting arms and ammunition would be deposited into the Federal Aid to Wildlife Restoration Fund.

The Federal Aid in Wildlife Restoration Act Amendments of 1970 (Title I of Public Law 91-503), added provisions for the deposit of the amounts equivalent to excise taxes on pistols and revolvers into the Fund beginning in fiscal year 1971. Public Law 92-558 added provisions for the deposit of amounts equivalent to the excise taxes on bows and arrows and their parts and accessories into the Fund beginning with fiscal year 1975.

FINANCING MECHANISM

To carry out wildlife restoration projects, there is authorized to be appropriated an amount equal to all revenues accruing from any tax imposed by Internal Revenue Code section 4161(b) on bows, arrows, and parts and accessories and section 4181 on pistols, revolvers, other firearms, shells, and cartridges. Section 4161 imposes an excise tax of 11 percent of the price for which bows with a draw weight of 10 pounds or more; arrows that measure 18 inches overall or more in length or arrows that measure less than 18 inches in overall length which are suitable for use with a taxable bow; and parts, accessories, or quivers suitable for use with taxable bows are sold by a manufacturer, producer, or importer. Section 4181 imposes a similar tax of 10 percent upon the sale of pistols and revolvers and 11 percent on other firearms, shells, and cartridges. Section 4182 provides exemptions for certain machine guns and short barrelled firearms (on which a transfer tax has been paid under section 5811) and sales to the Defense Department.

EXPENDITURE PURPOSES

Any State which wishes to receive any of these appropriations must assent to the provisions of Chapter 5B of U.S. Code Title 16 and enact laws for the conservation of wildlife including a prohibition against the diversion of license fees paid by hunters for any purpose other than the administration of the State fish and game department. The Secretary of the Interior and the State fish and game department must agree upon the wildlife restoration projects to be aided in the State. The project must conform to the standards fixed by the Secretary of the Interior.

A wildlife restoration project is defined to include the selection, restoration, rehabilitation, and improvement of areas of land or water adaptable as feeding, resting, or breeding places for wildlife, including acquisition by purchase, condemnation, lease or gift of such areas or estates or interests therein as are suitable or capable of being made suitable therefor, and the construction thereon or therein of such works as may be necessary to make them available for such purposes. The term includes also such research into problems of wildlife management as may be necessary to efficient administration affecting wildlife resources.

The authorized revenues are made available until expended. Amounts not spent by a State within two fiscal years are made available for expenditure by the Secretary of the Interior to carry out the provisions of the Migratory Bird Conservation Act (16 U.S.C. 715).

Up to 8 percent of the available funds are required to be apportioned as the Secretary of the Interior estimates necessary to administer the Migratory Bird Conservation Act. The remainder of the revenue (except as provided in the following paragraph) is apportioned among the States in the following manner: one-half in the ratio which the area of each State bears to the total area of all the States, and one-half in the ratio which the number of paid hunting-license holders of each State (2 years earlier) bears to the total number of paid license holders of all the States. No State is to receive less than one-half of 1 percent or more than 5 percent of the total amount apportioned.

One-half of the revenues from the tax imposed on pistols, revolvers, bows, and arrows is to be apportioned among the States in proportion to the ratio that the population of each State bears to the population of all the States. Each State is to be apportioned between 1 and 3 percent of the revenue under this population apportionment.

Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, and the Virgin Islands can also be appropriated limited amounts of these revenues.

MISCELLANEOUS

Statutory language providing the permanent authorization and related matters is located at 16 U.S.C. 669 and following.

The Committee on Merchant Marine and Fisheries has jurisdiction over expenditures for wildlife restoration projects.

Section 12. Reforestation Trust Fund

LEGISLATIVE HISTORY

In 1980, the Congress enacted Title III of Public Law 96-451 which provided for the amortization of certain reforestation expenses and established the Reforestation Trust Fund.

In 1982, provisions were enacted as part of the Surface Transportation Assistance Act of 1982 (H.R. 6211, P.L. 97-424) directing the Secretary of Agriculture to expend all amounts in the Trust Fund during fiscal years 1983, 1984, and 1985, and directing that the Secretary spend not less than $104 million in fiscal year 1983. The 1982 Act also stated that it is the intent of the Congress that amounts remaining in the Trust Fund from the earlier period as of October 1, 1985, are to be distributed to the States for use in State forestry programs no later than April 30, 1986.

FINANCING MECHANISM

Funds for the Reforestation Trust Fund are derived from import duties on plywood and lumber. The Secretary of the Treasury is required to transfer receipts from these tariffs to the Trust Fund in maximum amounts of $30 million for each fiscal year. In addition, the Trust Fund earns interest on investments of any cash balance.

EXPENDITURE PURPOSES

Funds are to be used to supplement congressional appropriations for reforestation and timber stock improvement on publicly owned national forests, in order to eliminate and prevent a backlog in reforestation of the National Forest System.

For each of the five fiscal years from fiscal year 1981 through fiscal year 1985, appropriations were authorized from the Trust Fund to the Secretary of Agriculture to pay estimated necessary direct costs and properly allocable administrative costs for reforestation and related programs (under section 3(d)(2)) of the Forest Rangeland Resources Planning Act of 1974 (16 U.S.C. 1601(d)(2)), but only to the extent these estimated costs exceeded amounts appropriated out of the general fund for these purposes.

While the expenditure language regarding the Trust Fund appears to provide expenditure purposes only through fiscal year 1985, it does add that it is the intent of the Congress that the Secretary of Agriculture expend all of the funds available in the Trust Fund in each fiscal year. Any such funds which are not expended in a given fiscal year shall remain available for expenditure without fiscal year limitation (except as noted above).

MISCELLANEOUS

After consulting with the Secretary of Agriculture, the Secretary of the Treasury must submit annual reports to the Congress setting forth the financial condition and operating results of the Reforestation Trust Fund for the preceding fiscal year and the expected condition and results of the Trust Fund for the next year.

The statutory language establishing the Reforestation Trust Fund and governing its operations are located at 16 U.S.C. 1606(a).

FINANCIAL STATUS OF FUND

The table below describes the program and financing for the Trust Fund.

REFORESTATION TRUST FUND

[In thousands of dollars]

	1987 actual	1988 estimate	1989 estimate
Unobligated balance, start of year	−5,007	−4,675	−4,675
Total obligations	33,159	30,000	30,000
Budget authority (appropriation)	31,196	30,000	30,000
Unobligated balance, end of year	4,675	4,675	4,675
Unobligated balance restored	−1,631		

Source: U.S. Budget Appendix, Fiscal Year 1989.

Section 13. Deep Seabed Revenue Sharing Trust Fund

LEGISLATIVE HISTORY

The Deep Seabed Revenue Sharing Trust Fund was established in 1979 by Title IX of the Deep Seabed Hard Mineral Resources Act (Public Law 96-223). The purpose of the Trust Fund is to accelerate the program of environmental assessment of exploration for and commercial recovery of hard mineral resources of the deep seabed and assure that such exploration and recovery activities are conducted in a manner which will encourage the conservation of such resources, protect the quality of the environment, and promote the safety of life and property at sea. An additional purpose is to encourage continued development of deep seabed mining technology.

FINANCING MECHANISM

The Deep Seabed Revenue Sharing Trust Fund is funded by amounts determined by the Secretary of the Treasury to be equivalent to the amount of the excise taxes received in the Treasury under the Deep Seabed Hard Mineral Removal Tax Act of 1979. The excise tax, imposed under Internal Revenue Code section 4495, is 3.75 percent of the "imputed value" of hard mineral resources removed from the deep seabed.[1] The tax became effective on January 1, 1980, and terminates after the earlier of the date on which an international deep seabed treaty takes effect with respect to the United States or on June 29, 1990.

A mining company can elect to have the application of the excise tax suspended with respect to one or more commercially recoverable metals or minerals contained in the nodules removed from the deep seabed if the mining company does not intend to process, use commercially, or sell that metal or mineral within one year after the date of extraction. If a mining company elects to suspend the tax on a mineral and later processes, uses, or sells that mineral, then the mining company is liable for the excise tax and interest on the deferred amount. The interest is to be paid into the Trust Fund and will be treated like other amounts in the Trust Fund. If the additional tax is paid after substantial disposition of Trust Fund assets by Congress, the additional tax is to be disposed of in a manner provided in the legislation making the substantial disposition or in subsequent acts.

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[1] The "imputed value" is equal to 20 percent of the fair market value of the commercially recoverable metals and minerals in such resource. Thus, the effective tax rate is 0.75 percent of the fair market value of the resource.

EXPENDITURES PURPOSES

Appropriations have been authorized from the Trust Fund for making contributions which may be required pursuant to an international deep seabed treaty which may become effective with respect to the United States on or before June 28, 1990. Trust Fund amounts may be appropriated for making contributions required under such a treaty for the purpose of sharing the revenue from deep seabed mining among nations of the world.

In the event that an international deep seabed treaty does not become effective with respect to the United States on or before June 28, 1990, amounts in the Trust Fund will be available for such purposes as Congress may provide by law. Thus, if an international deep seabed treaty is not in effect with respect to the United States prior to June 29, 1990, amounts in the Trust Fund will be disposed of only in accordance with an act of Congress.

MISCELLANEOUS

The Secretary of the Treasury is required to submit an annual report to the Congress with respect to the Deep Seabed Revenue Sharing Turst Fund beginning with the fiscal year ending September 30, 1980.

The Statutory provisions establishing the Deep Seabed Revenue Sharing Trust Fund and governing its operation are located at 30 U.S.C. 1472.

FINANCIAL STATUS OF FUND

Since no treaty is yet in effect, there have been no appropriations from the Fund. No revenues are expected from the excise tax until the late 1980's. At that time it is estimated that the tax will raise a maximum of $5 million in annual net revenues (gross revenue less income tax lost because of deductibility of the tax).

Section 14. Tax Court Judges Survivors Annuity Fund

LEGISLATIVE HISTORY

The Tax Court Judges Survivors Annuity Fund was enacted in Public Law 87-370 on October 4, 1961. Amendments which increase the annuity amounts payable from the Fund were enacted in Public Law 97-362 (H.R. 4717) on October 25, 1982. Amendments to increase the maximum annuities receivable by surviving children of a deceased Tax Court judge where the judge also leaves a surviving spouse were enacted in Public Law 98-369 (H.R. 4170) on July 18, 1984. Amendments to make the survivors annuity provisions relating to Tax Court judges parallel to those applicable to other Federal judges, following enactment of Public Law 99-336, were enacted in Public Law 99-514 (H.R. 3838), generally effective on November 1, 1986. Internal Revenue Code section 7448 provides the statutory basis for the annuities to surviving spouses and dependent children of Tax Court judges.

FINANCING MECHANISM

Any judge of the United States Tax Court may by written election while a judge (or before a successor takes office) participate in the Fund. There is deducted and withheld from the salary of each judge electing to participate 3.5 percent of that judge's salary. The amounts deducted and withheld are deposited, in accordance with procedures prescribed by the Comptroller General of the United States, in the U.S. Treasury to the credit of the Tax Court Judges Survivors Annuity Fund. A judge may deposit, with interest at 4 percent per annum to December 31, 1947, and at 3 percent per annum thereafter, compounded on December 31 of each year, to the credit of the Fund, a sum equal to 3 percent of the judge's salary and of that individual's basic salary, pay, or compensation for service as a Senator, Representative, Delegate, or Resident Commissioner in Congress, and for any other civilian service within the purview of 5 U.S.C. 8332 for services performed before November 1, 1986, and 3.5 percent for services performed after November 1, 1986. Each judge may elect to make the deposits in installments during continuance of service as a judge in such amount and under such conditions as may be determined in each instance by the chief judge of the Tax Court.

Notwithstanding the failure of a judge to make the deposit, credit is allowed for the service rendered, but the annuity of the surviving spouse of the judge is reduced by an amount equal to 10 percent of the amount of the deposit, computed as of the date of the death of the judge (unless the surviving spouse elects not to count the service, for which the deposit was not made, in determining the annuity due). No deposit is required from a judge for any year with respect to which deductions from salary were actually made under the civil service retirement laws. Also, no deposit is required for any honorable service in the Army, Navy, Air Force, Marine Corps, or Coast Guard of the United States.

EXPENDITURE PURPOSES

The Fund is used to pay annuities to a deceased judge's surviving spouse and children.

If a judge who elects to participate in the Fund dies after having rendered at least 5 years of civilian service for which salary was withheld for the Fund (or for which salary was withheld under the civil service retirement laws), a surviving spouse or surviving dependent child is entitled to an annuity from the Fund. If the surviving spouse has not attained age 50 at the date of the judge's death (and no dependent child survives), the annuity commences when the surviving spouse reaches age 50. The annuity payable to a surviving spouse terminates upon the surviving spouse's death or remarriage. An annuity payable to a dependent child and to a surviving spouse, if the judge is also survived by a dependent child, begins immediately after the judge's death. The annuity for a dependent child terminates generally upon the surviving child's reaching 18 years of age, marriage, or death. If the child is incapable of self support because of mental or physical disability, the annuity would terminate only upon death, marriage, or recovery from the disability.

The annuity payable to a surviving spouse of a judge electing under the Fund is equal to a stated percentage (generally 1¼ percent) of the average annual salary received by the judge (whether the judge's salary or compensation for other allowable Federal service) for the 5 consecutive years in which the judge received the largest average annual salary, multiplied by the sum of years of judicial or other allowable Federal service. The annuity for the surviving spouse cannot exceed 37½ percent of the average annual salary of the judge. The annuity of the surviving spouse will be reduced to account for periods of time when the judge did not contribute to the Fund. The amount of the annuity payable to a surviving dependent is based upon the annuity payable to a surviving spouse (subject to certain limits).

Under the 1982 amendments, annuities payable with respect to judges dying after the date of enactment are increased by (1) basing the annuity on the judges' salary for the 3 (versus 5) consecutive years in which the judges received the largest average annual salary, and (2) increasing the maximum annuity to 40 percent (versus 37½ percent) of such average annual salary. These amendments also provide that survivor annuities will be adjusted for cost-of-living increases by increasing such annuities by 3 percent for each 5 percent by which the salary of Tax Court judges is increased. Annuities in pay status on the date of enactment are adjusted immediately to reflect post-1963 salary increases.

Under the 1984 amendments, the maximum annuities receivable by surviving children of a deceased Tax Court judge where the judge also leaves a surviving spouse are increased from $900 per year per family ($360 per child) to $4,644 per year per family

($1,548 per child). Where there is no surviving spouse, the maximum annuities for surviving dependent children are increased to $5,580 per year per family, or $1,860 per child, whichever is less. These increases are effective for annuities payable for months beginning after July 18, 1984.

Under the 1986 Tax Reform Act, the judges' salary contribution to the fund and civilian service for benefits to be payable under the program increased from 3 percent to 3.5 percent. The annuity for a surviving spouse increased to 1½ percent (verses 1¼ percent) of the judge's average salary per the 3-year consecutive year requirement, but cannot exceed 50 percent (versus 40 percent) of the average annual salary, nor be less than 25 percent of the average annual salary. The annuity payable to a surviving spouse does not terminate upon remarrige at age 55 or older. Where there are children and a surviving spouse, the maximum annuity per child is the lesser of 10 percent of the average annual salary, or 20 percent of the average annual salary divided by the number of children (versus the lesser of 50 percent of the spouse's annuity to $4,644 per year per family, or $1,548 per child). Where there is no surviving spouse, the maximum annuity per child is the lesser of 20 percent of the average annual salary or 40 percent of the average annual salary divided by the number of children (versus an amount equal to what spouse would have received if surviving not to exceed $5,580 per year per family, or $1,860 per child, which ever is less). Judges who retire under a new retirement election, i.e., fixed salary and opportunity to practice law, will continue to have the prescribed deduction (3.5 percent) withheld from their retired pay and will receive credit for those years of contribution. A judge who "ceases to be married" after electing to participate in the Fund may terminate his participation and receive a refund of contributions plus interest. The increase in salary deductions is effective November 1, 1986. The increase in the civilian service percentage is effective for service performed after November 1, 1986. The amendments apply to annuities starting after November 1, 1986. Any judge electing prior to November 1, 1986, to participate in the fund may revoke that election within the 180-day period beginning after enactment and receive a refund of contributions plus interest. Any judge who revokes within the 180-day period may later participate only upon repayment of entire refund plus interest.

Financial Status of Fund

As of September 30, 1987, 25 judges of the Tax Court were participating in the Fund, and 3 eligible widows were receiving survivor annuities.

Actual outlays for fiscal year 1985, 1986 and 1987 were $26,000, $53,000 and $60,000 respectively; and estimated outlays for fiscal years 1988 and 1989 are $59,000 for each year.

Section 15. Railroad Retirement System

The railroad retirement system is a federally legislated program which provides retirement, disability and survivor annuities to workers whose employment was connected with the railroad industry for at least 10 years. The system, in existence since 1936, was substantially modified by the Railroad Retirement Act of 1974 (RRA), which provided for closer coordination with the social security system. Credits are primarily secured by employment in the railroad industry, although any social security credits earned during employees' work careers are included in the benefit computation. Benefits are financed through a combination of employee, employer, and Federal Government contributions.

Retirement and survivor benefit payments during fiscal year 1987 totaled $6,520 million. These payments were made to approximately 994,000 beneficiaries. Retired employee and spouse annuitants constituted 675,000 of these beneficiaries and received $4,774 million. Survivor beneficiaries received a total of $1,747 million, consisting of $1,737 million in monthly benefits and $10 million in lump-sum payments.

JURISDICTION

In the House of Representatives, the jurisdiction over the railroad retirement system is divided between two standing committees. Under the rules of the House, the Energy and Commerce Committee has jurisdiction over "railroads, including railroad labor, railroad retirement and unemployment, except revenue measures related thereto." That committee therefore has jurisdiction over the Railroad Retirement Act, which contains the substantive legislation relating to railroad retirement legislation. The Committee on Ways and Means has jurisdiction over all revenue measures, including the Railroad Retirement Tax Act (Chapter 22 of the Internal Revenue Code of 1954). Within the Committee on Ways and Means jurisdiction over employment taxes and trust fund operations relating to the railroad retirement system lies within the Subcommittee on Social Security.

HISTORICAL DEVELOPMENT

In the final quarter of the 19th century, railroad companies were among the largest in America. It was in the rail industry that the first industrial pension was established in 1874. By the mid-1920's more than 80 percent of all rail workers were covered by pension plans.

In the early 1930's these pension plans began to face enormous financial problems. The commercial success of the rail industry peaked in the period between 1900 and 1920, and rail employment decreased significantly in the 1920's.

Rail pension plans were for the most part poorly constructed. There was no regulation of plan terminations, which were frequent. Pension funds were chronically underfinanced, and most could not stand the financial exigencies of the depression.

These problems plus a tradition of Federal regulation of the railroads led to the enactment of the Railroad Retirement Act of 1934.

The original railroad retirement system was structured to provide annuities to retirees based on rail earnings and length of service. Benefits were disbursed for retirees at age 65, although workers with 30 years of service could retire at 60, with a reduction in payments. The original disability provisions were very stringent. Little was provided for dependents, and nothing for spouses.

Throughout its history, the railroad retirement system has been modified many times by Congress. In the late 1940's and 1950's benefits were liberalized, and the railroad retirement system was brought into closer conformity with social security. For instance, in 1946, benefits were extended to survivors, based on combined railroad and social security covered employment. This extension represented a concern for the social goal of providing income security in old age, or social insurance, rather than simply rewarding career performance.

In the past decade and a half, the railroad retirement system has encountered recurrent financial crises as a result of employment declines in the industry, inflation, and the increase in the number of beneficiaries. Major legislation was enacted in 1974, 1981, and 1983 to prevent the system from becoming insolvent.

Currently the Railroad retirement system holds a substantial reserve. The continuing decline in rail employment has, however, raised questions concerning the practicality of relying on payroll tax funding in the next century. The Omnibus Budget Reconciliation Act of 1987 established a commission to review alternative methods of funding and to make recommendations to the President and Congress by October 1, 1989.

1980's Legislation

In 1981, the Committee on Ways and Means included in the Economic Recovery Tax Act (Public Law 97-34) payroll tax rate increases for both employers and employees. The Committee on Energy and Commerce included benefit changes and a "benefit preservation mechanism" in the 1981 Reconciliation Act (sec. 1126(b), Public Law 97-35).

As a result of substantial reductions in rail employment following the national economic recession of 1982, the railroad retirement system was threatened with insolvency in 1983. In order to prevent financial crisis and to avoid the benefit reduction which would have been required as a result of the benefit preservation mechanism (approximately 40 percent in tier II benefits, effective October 1, 1983), Congress enacted the Railroad Retirement Solvency Act of 1983 (Public Law 98-76). This package contained tax increases, benefit reductions, and direct Federal assistance.

A summary of those railroad retirement provisions included in Public Law 98-76 which were reported by the Committee on Ways and Means include the following:

(1) Provide three equal tax rate increases for both employer (1 percent) and employees (0.75 percent), effective on January 1, 1984, January 1, 1985, and January 1, 1986.

(2) Apply railroad retirement tier I and tier II taxes to an annual amount equal to 12 times the current applicable monthly wage base.

(3) Tax vested dual benefits as a private pension and deposit proceeds to the Railroad Retirement Account until fiscal year 1989. Beginning in fiscal year 1989, the proceeds from the tax will be deposited in the Dual Benefits Payments Account.

(4) Tax tier II benefits as a private pension and return proceeds to the Railroad Retirement Account until the earlier of fiscal year 1989; or the time when the amount of revenue transferred under this provision equals $877 million. Beginning in fiscal year 1989 the proceeds from the tax would be deposited in the general fund.

(5) Accelerate the employer payroll tax deposit schedule, to conform to the FICA deposit schedule.

(6) Create a "Social Security Equivalent Benefit Account" and deposit in the account all "social security equivalent" revenues. Pay all social security equivalent benefits out of the account.

(7) Provide that on July 1, 1985, and each subsequent July 1, the Railroad Retirement Board shall submit to the Congress a report on the actuarial status of the railroad retirement system and make any recommendation for financing changes that might be advisable, including adjustments in the level of tier II tax rates.

Following such a Board report questioning the feasibility of payroll tax financing in the next century, the Committee on Ways and Means included railroad retirement financing amendments in the Omnibus Budget Reconciliation Act of 1987.

The legislation established a Commission on Railroad Retirement Reform to conduct a comprehensive study of the issues pertaining to the long-term financing of the railroad retirement system. The Commission will submit recommendations to the Congress for revisions in, or alternatives to, the current payroll tax method of financing in order to assure the provision of retirement benefits to current and future retirees on an actuarially sound basis. The Commission, to consist of seven members representing railroads, including commuter railroads, labor, and the public, is to submit its report to the President and both Houses of Congress by October 1, 1989.

In the meantime, tier II tax rates were increased in January 1988 by a total of 2 percent, 1.35 percent on employers and 0.65 percent on employees. The new law also extended for 1 year, until October 1, 1989, the time during which revenues from Federal income taxes on tier II railroad retirement benefits may be transferred to the Railroad Retirement Account for use in paying benefits.

BENEFIT STRUCTURE

The 1974 Railroad Retirement Act established three benefit components. The ongoing benefit system was divided into two "tiers," one of which roughly approximates Social Security (tier I), and the other, an industry staff retirement benefit (tier II). The third component, a vested dual benefit, preserved certain benefits for employees who had qualified for both railroad retirement and Social Security benefits prior to the 1974 Act.

Tier I

These benefits are based on the Social Security formula, using both the employee's combined railroad earnings and non-railroad Social Security covered earnings up to the Social Security maximum wage base. The tier I benefit is roughly equal to what the Social Security benefit would have been had the worker's railroad employment been covered by the Social Security program. Because the railroad retirement tier I benefit is based on both Social Security and railroad employment, any Social Security benefit to which the railroad retirement system beneficiary is also entitled is subtracted from the tier I benefit amount. Tier I benefits are adjusted for the cost-of-living by the same percentage as Social Security benefits. For the purposes of the Balanced Budget and Emergency Deficit Control Act (Gramm-Rudman), tier I benefits are exempt from automatic spending reductions.

Tier II

Tier II benefits are based on the employee's service in the railroad industry alone and are payable in addition to the tier I benefit amount. For current retirees, the tier II benefit is equal to seven-tenths of 1 percent of the employee's average monthly earnings in the 60 months of highest earnings, times the total number of years of railroad service, less 25 percent of any employee vested dual benefit also payable. Since 1985, tier II benefits are automatically adjusted annually on January 1 at a rate equal to 32.5 percent of the Social Security automatic cost-of-living adjustment. The 1986 tier II increase was suspended under the Gramm-Rudman Act, but the Omnibus Budget Reconciliation Act enacted October 21, 1986 (Public Law 99-509) exempted future tier II COLA's from sequestration under Gramm-Rudman.

Dual benefit payments

One of the chief purposes of the Railroad Retirement Act of 1974 was to coordinate railroad retirement and Social Security benefit payments to eliminate certain dual benefits considered to be a "windfall" for persons receiving benefits under both systems.

This "windfall" was a result of the fact that the total benefit these retirees received from both systems was higher than the benefit they would have received if their benefit was based on their total career earnings but paid only under railroad retirement. The total benefit was higher in these cases since the Social Security benefit formula favors workers who have low average earnings throughout their careers. Low career average earnings result from a career of low wages or from a relatively short career in Social

Security covered employment. Workers who spend a period of time in employment not covered by Social Security, such as railroad employment, receive the benefit of this "tilt" in the benefit formula, even though they may very well not have had low career earnings.

As a result of the 1974 Act, "windfall" benefits were eliminated for any railroad employees not qualified for such benefits as of January 1, 1975. They were generally preserved for those individuals who were vested under both the railroad retirement and Social Security systems before 1975. These vested dual benefits are financed out of the general revenue fund through an annual appropriation rather than from the Social Security or railroad retirement trust funds. Under the Balanced Budget and Emergency Deficit Control Act of 1985, vested dual benefit payments were reduced during fiscal year 1986 as a controllable expenditure. The Omnibus Budget Reconciliation Act enacted in October 1986 exempted vested dual benefit payments from any future sequestrations under the Gramm-Rudman Act. However, the December 1987 Federal budget legislation, reducing domestic discretionary spending for fiscal year 1988 by 4.26 percent, reduced the funds available for payment of vested dual benefits from $368,000,000 to $352,323,000 in the 1988 fiscal year. Currently paid to about one-fourth of the Board's 1 million beneficiaries, the average vested dual benefit of $110 per month was reduced by an average of $6 per month.

Supplemental annuities

These are provided under the 1974 Act equal to $23 for 25 years of service plus $4 for each additional year up to a maximum of $43 per month. However, as a result of the 1981 Omnibus Budget Reconciliation Act, employees hired after October 1, 1981 are not eligible for supplemental annuities when they retire. Supplemental annuities were temporarily reduced by 8.5 percent during fiscal year 1988 under Gramm-Rudman. Withheld amounts were later repaid.

Lump sum death benefits

These benefits are paid when there is no person eligible for a monthly survivor benefit in the month in which the worker died. Generally, 10 years of railroad service and a current connection with the railroad industry are required. For employees with 10 or more years of railroad service before 1975, the amount is based on the 1937 Act. For all other railroad workers, the amount is equivalent to that which would be paid under the Social Security Act (unless survivor benefits are paid).

Table 1 provides data concerning all railroad retirement benefits being paid at the end of fiscal years 1978–1987. Table 2 presents data on new awards for November 1987.

TABLE 1.—NUMBER AND AVERAGE AMOUNT OF RETIREMENT AND SURVIVOR ANNUITIES IN CURRENT-PAYMENT STATUS AT END OF YEAR, FOR SELECTED YEARS, BY TYPE OF ANNUITANT

Fiscal year	Total	Type of beneficiary										
		Retired employees										
		Age	Disability	Supplemental	Spouses	Divorced spouses	Aged widows	Disabled widows	Widowed mothers	Divorced and remarried widows	Children	Parents
Number at end of year:												
1971	1,067,121	348,737	95,364	81,611	212,075		278,741	2,972	8,076		39,096	449
1975	1,160,312	359,826	101,677	141,525	219,644		290,502	5,108	7,061		34,670	299
1977	1,201,059	364,402	99,672	169,257	230,758		292,653	6,206	6,298		31,566	243
1978	1,203,895	361,760	98,253	176,271	232,472		292,300	6,470	5,930		30,224	215
1979	1,204,719	358,629	96,818	182,736	233,611		292,073	6,770	5,406		28,478	198
1980	1,203,006	355,983	95,218	188,111	233,916		290,315	6,999	4,985		27,288	189
1981	1,202,364	354,608	93,743	193,436	233,977		288,606	7,249	4,478		26,094	173
1982	1,200,427	352,609	92,146	197,885	234,009	(1)	286,193	7,376	4,053	(2)	22,172	158
1983	1,193,226	349,892	89,684	201,409	232,367	(1)	288,454	7,509	3,153	(2)	20,614	144
1984	1,182,606	345,842	87,924	202,055	228,978	1,455	279,383	7,425	2,908	7,276	19,226	134
1985	1,165,202	339,696	85,685	201,140	225,587	1,697	274,954	7,465	2,655	8,355	17,845	123
1986	1,151,861	335,126	83,888	200,534	222,742	1,900	270,696	7,471	2,536	9,360	17,488	120
1987	1,139,782	330,676	83,082	200,266	220,135	2,168	266,020	7,465	2,467	10,260	17,130	113

Average amount:										
1971	$201	$186	$65	$95	....	$114	$115	$158	....	$112	$110
1975	329	309	62	153	....	233	200	234	....	206	187
1977	387	355	57	178	....	267	228	275	....	248	223
1978	417	380	55	191	....	285	242	301	....	269	241
1979	461	419	54	210	....	314	265	336	....	300	273
1980	526	477	53	236	....	361	302	392	....	349	310
1981	579	525	52	251	....	401	331	442	....	393	357
1982	641	576	51	280	(1)	430	354	475	(2)	399	368
1983	663	593	50	287	(1)	432	355	475	(2)	394	367
1984	682	609	49	293	$167	441	415	478	$269	400	369
1985	711	639	49	305	174	455	427	487	284	415	375
1986	745	674	48	317	179	472	439	498	299	427	379
1987	773	708	47	327	187	480	447	485	308	432	388

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[1] Included with spouse annuities.

[2] Included with aged and disabled widow and widowed mother annuities.

Note.—Data exclude survivor (option) annuities. On September 30, 1987, there were 83 option annuities in current payment status averaging $96. Figures for widows include a small number of widowers.

Source: Railroad Retirement Board.

TABLE 2.—NUMBER AND AVERAGE AMOUNT OF NEW AWARDS BY BENEFICIARY TYPE, NOVEMBER 1987

	Number	Average amount
Employee annuities:		
Retired	1,030	$976
Disability (under age 65)	236	1,067
Supplemental	536	42
Spouse annuities	1,034	335
Divorced spouse annuities	39	186
Survivor benefits:		
Aged widows and widowers	981	529
Disabled widows and widowers	18	382
Widowed mothers and fathers	26	413
Divorced and remarried widows	104	339
Children	77	468
Parents		
Insurance lump sums	475	847
Residual payments	19	5,364
Total	4,575	

Source: Railroad Retirement Board.

FINANCING THE RAILROAD RETIREMENT SYSTEM

Railroad retirement and survivor benefits are financed by six sources of income. These are (1) payroll taxes on railroad earnings paid by covered employees and employers up to a certain maximum wage base; (2) income from the Social Security financial interchange; (3) proceeds derived from the taxation of railroad retirement benefits; (4) appropriations from general revenues; (5) interest on investments; and (6) a cents-per-hour tax levied on carriers only.

Payroll Taxes

The primary source of income to the railroad retirement account is payroll taxes levied on covered employers and their employees. Currently, both employers and employees pay a "tier I" tax which is equivalent to the Social Security tax rate. In addition, a "tier II" tax is paid by both rail employers and employees. The 1988 annual tier I and tier II wage bases are $45,000 and $33,600, respectively.

The scheduled tax rates for both tier I and tier II are as follows:

	Tier I		Wage base	Tier II		Wage base	Combined	
	Employer	Employee		Employer	Employee		Employer	Employee
1975	5.85	5.85	$14,100	9.5	0	$14,100	15.35	5.85
1980	6.13	6.13	25,900	9.5	0	20,400	15.63	6.13
1984	7.00	[1] 7.00	37,800	12.75	2.75		19.75	9.75
1985	7.05	7.05	39,600	13.75	3.50		20.80	10.55

	Tier I		Wage base	Tier II		Wage base	Combined	
	Employer	Employee		Employer	Employee		Employer	Employee
1986	7.15	7.15	42,000	14.75	4.25		21.90	11.40
1987	7.15	7.15	43,800	14.75	4.25	32,700	21.90	11.40
1988	7.51	7.51	45,000	16.10	4.90	33,600	23.61	12.41
1989 [2]	7.51	7.51	46,500	16.10	4.90	34,500	23.61	12.41
1990 [2]	7.65	7.65	48,900	16.10	4.90	36,300	23.75	12.55
1991 [2]	7.65	7.65	51,600	16.10	4.90	38,100	23.75	12.55
1992 [2]	7.65	7.65	54,600	16.10	4.90	40,200	23.75	12.55
1993 [2]	7.65	7.65	57,600	16.10	4.90	42,300	23.75	12.55

[1] A credit of 0.3 percent of wages was allowed against the 1984 employee tax rate. Appropriations to the Social Security Equivalent Benefit Account were based on the 7.00 percent rate.

[2] 1989–93 tier I and tier II wage bases are projected.

The tier I wage base is generally identical with the Social Security wage law and automatically increases with wage growth in the economy.

The tier II wage base is equal to what the Social Security tax rate would have been without regard to the ad hoc increases in the taxable wage base which were provided by the Social Security Amendments of 1977 (Public Law 95–215).

Financial Interchange

The railroad retirement system and the Social Security programs have been coordinated financially since 1951. The purpose of the financial interchange is to place the Social Security trust funds in the same position they would have been in if railroad employment had been covered under Social Security since its inception.

TABLE 3.—AMOUNTS TRANSFERRED TO OR FROM (−) THE RAILROAD RETIREMENT ACCOUNT [1] AND THE VARIOUS SOCIAL SECURITY TRUST FUNDS IN FISCAL YEARS 1954 THROUGH 1987

[In millions of dollars]

	OASI	DI	HI	Total
Fiscal year:				
Through June 30, 1954	−21.1			−21.1
1955	−7.4			−7.4
1956	−5.2			−5.2
1957	−1.6			−1.6
1958	124.4			124.4
1959	282.0	−22.0		260.0
1960	318.4	−4.9		313.5
1961	331.7	5.1		336.9
1962	360.8	11.0		371.8
1963	422.5	19.6		442.1
1964	402.6	19.1		421.8
1965	435.6	23.6		459.3
1966	443.8	25.0		468.8

TABLE 3.—AMOUNTS TRANSFERRED TO OR FROM (−) THE RAILROAD RETIREMENT ACCOUNT [1] AND THE VARIOUS SOCIAL SECURITY TRUST FUNDS IN FISCAL YEARS 1954 THROUGH 1987—Continued

[In millions of dollars]

	OASI	DI	HI	Total
1967	508.0	30.6	−16.3	522.4
1968	437.6	20.4	−44.0	414.0
1969	491.5	21.3	−54.2	458.6
1970	578.8	10.4	−63.5	525.7
1971	613.0	13.2	−65.9	560.3
1972	724.3	24.2	−66.1	682.4
1973	783.0	19.5	−63.2	739.2
1974	908.6	22.3	−99.2	831.7
1975	981.8	28.5	−132.5	877.8
1976	1,212.3	26.4	−137.7	1,100.9
1977	1,207.8	−0.3	−142.9	1,064.7
1978 [2]	1,588.7	29.8	−213.7	1,404.7
1979	1,447.5	29.9	−191.1	1,286.3
1980	1,442.0	−12.1	−244.3	1,185.6
1981	1,584.9	29.4	−276.5	1,337.9
1982	1,793.3	26.4	−351.4	1,468.2
1983	2,250.8	27.8	−357.7	1,920.9
1984	2,404.0	21.6	−350.6	2,075.0
1985	2,310.2	42.7	−371.4	1,981.5
1986	2,585.1	67.7	−364.4	2,288.4
1987	2,557.3	56.9	−368.0	2,246.2
Total	31,497.2	613.4	−3,974.7	28,135.8

[1] Beginning in 1985, transfers are to or from the Social Security Equivalent Benefit Account.

[2] Includes transfers for July–September 1976 transition quarter.

Note.—Detail may not add to totals because of rounding.

Source: Railroad Retirement Board.

Generally, under the interchange, for a given fiscal year there is computed the revenue that would have been collected by the Social Security trust funds if railroad employment had been covered directly by Social Security. This amount is netted against the amount of benefits Social Security would have paid to railroad beneficiaries based on railroad and nonrailroad earnings during that period. Where Social Security benefits that would have been paid exceed income to the trust funds that would have been due, the excess, plus an allowance for interest and administrative expenses, is transferred from the Social Security trust funds to the RRB's Social Security Equivalent Benefit Account. If income exceeds benefits, the transfer would be from the RRB's Social Security Equivalent Benefit Account to the Social Security trust funds. Before 1985, transfers were to or from the Railroad Retirement Account.

The determination of the amount to be transferred through the financial interchange for a given fiscal year is made no later than

June of the year following the close of the preceding fiscal year. Table 3 shows the actual operation of the financial interchange as it relates to each of the three major Social Security trust funds.

In order to make available to the RRB's Social Security Equivalent Benefit Account funds from the forthcoming financial interchange on a more current basis, the Railroad Retirement Solvency Act of 1983 provided for transfers from general Treasury funds to the RRB's Social Security Equivalent Benefit Account for each month an amount equal to the Social Security level benefits paid from the account during the month less the Social Security level taxes received by the account in that month. The amount so transferred for a particular month is repaid when the Social Security system makes reimbursement for that month under the financial interchange program.

Taxation of benefits

Prior to 1984, railroad retirement benefits, with the exception of supplemental annuities, were not subject to Federal income taxation. However, as a result of the Railroad Retirement Solvency Act (Public Law 98–76) and the Social Security Act Amendments of 1983 (Public Law 98–21), certain tier I, and all tier II, and vested dual benefits received after December 31, 1983, are subject to taxation. The taxation provisions were subsequently amended by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986. The budget reconciliation legislation limited the amount of tier I benefits treated as Social Security benefits for tax purposes to Social Security equivalent levels. The Tax Reform Act eliminated the 3-year recovery rule so that railroad retirement benefits exceeding Social Security equivalent levels are taxable immediately upon retirement under the general rule, with previously taxed contributions prorated over estimated life expectancies.

The Social Security equivalent portions of tier I benefits are taxed in a manner identical to Social Security benefits. The proceeds derived from the taxation of those tier I benefits which are equivalent to Social Security benefits will be deposited in the Social Security Equivalent Benefit Account and credited to the Social Security trust funds through adjustments in the financial interchange. Tier I benefits in excess of Social Security equivalent levels (early retirement benefits payable at ages 60–61 and occupational disability annuities) and tier II benefits are taxed in a manner identical to private pensions and the proceeds are deposited in the Railroad Retirement Account through fiscal year 1989. Vested dual benefits are taxed as a private pension with the proceeds derived deposited in the Railroad Retirement Account until fiscal year 1989 and in the Dual Benefits Payments Account thereafter.

General revenue appropriations

Vested dual benefits are funded solely through general revenue appropriations. The Congress authorized such funding in the 1974 act through the year 2000. The total appropriated for the first 12 fiscal years for which these benefits were payable, 1976–1987, was $4,126 million.

The Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) established a Dual Benefits Payments Account. Each year an amount which is appropriated for the payment of vested dual benefits will be placed into this account from which these payments will be made to beneficiaries. If the amount which is appropriated is insufficient to pay the full vested dual benefits to all eligible beneficiaries for a full year, the Railroad Retirement Board is authorized to prorate payments from the dual benefits account so that the amounts paid do not exceed the amounts appropriated.

In addition to amounts transferred to the Dual Benefits Payments Account annually through the regular appropriations process, the Railroad Retirement Solvency Act of 1983 provided for the appropriation of approximately $1.7 billion to the Railroad Retirement Account in three installments paid on Jan. 1, 1984, 1985, and 1986. These three appropriations were to reimburse the Railroad Retirement Account for prior shortfalls in the annual appropriations. The actual amounts received totaled $2.1 billion.

Interest from investments

Funds not needed immediately for benefit payments are invested in interest-bearing securities. During fiscal year 1987 the Railroad Retirement Account and Social Security Equivalent Benefit Account received $487 million in interest income from invested assets. This represents an annualized yield of 8.53 percent.

Cents-per-hour tax

A cents-per-hour tax is used to fund the supplemental annuity benefit. This tax is levied solely on employers. The rate is determined quarterly by the Railroad Retirement Board.

FINANCIAL STATUS OF THE RAILROAD RETIREMENT ACCOUNT

One of the most important factors affecting the financial status of the railroad retirement system is the level of employment in the industry. The recent history of industry employment follows:

TABLE 4.—HISTORIC LEVELS OF INDUSTRY EMPLOYMENT, 1940–87

[In thousands]

1940	1,195
1945	1,085
1950	1,421
1955	1,239
1960	909
1965	753
1970	640
1975	548
1976	540
1977	546
1978	542
1979	554
1980	532
1981	503
1982	440
1983	395
1984 [1]	395
1985 [1]	372
1986 [1]	342
1987	316

[1] Revised.

Source: Railroad Retirement Board.

While the Railroad Retirement Account currently has a reserve of about $6.5 billion, the continuing decline in railroad employment has raised questions concerning the financing of the railroad retirement system after the year 2000. Section 502 of the Railroad Retirement Solvency Act requires a report each year on the railroad retirement system's actuarial status, and financing recommendations when appropriate. Because of the decline in employment, the Board's Chief Actuary recommended in his 1987 report that a commission be established to study the advisability of instituting a tax on operating revenues to fund a portion of the cost of railroad retirement benefits, and that such a study should solicit the views of railroad labor, railroad management and other interested parties. He also recommended that tier II taxes be increased until any tax adjustments recommended by the commission become effective.

Congress created a Commission on Railroad Retirement Reform in the 1987 Omnibus Budget Reconciliation Act. The Commission will examine issues of future financing of Railroad Retirement benefits.

Section 16. Railroad Unemployment Compensation System

The railroad unemployment compensation (RRUC) system has been in existence since 1938. Railroad workers were initially covered by the unemployment provisions of the Social Security Act of 1935. The Railroad Unemployment Insurance Act (Public Law 75-722) was passed in 1938 to provide a uniform unemployment insurance system for all railroad workers, regardless of the State in which they worked or lived. This was done largely because of administrative problems at that time in handling claims for railroad workers who earned wages in a number of different States and as a result of the railroad unions' desire that individuals throughout the industry be treated the same for purposes of unemployment compensation.

BENEFITS AND ELIGIBILITY REQUIREMENTS

A worker must have at least $1,500 of creditable railroad earnings in the base year to qualify for RRUC benefits. In addition, if the worker has not worked in the railroad industry previously, he must have railroad earnings in at least 5 months of the base year. (The base year is the calendar year before the beginning of the benefit year which begins on July 1 for all claimants.) The first $600 of railroad earnings in each month are creditable toward the qualifying earnings requirement. Up to $775 per month in the base year is creditable toward the maximum benefit.

An unemployed worker who meets the qualifying requirements can receive RRUC benefits for each "day of unemployment." An individual, however, cannot receive benefits for more than 10 days of unemployment in any 2-week period. In order to receive a daily benefit, a worker must be able to work and be available for railroad work. He must also register for work at the railroad unemployment office.

A qualified, unemployed railroad worker may receive a daily unemployment compensation benefit equal to 60 percent of his last daily rate of pay in the base year, up to a maximum of $25. The minimum daily benefit is $12.70. The equivalent weekly RRUC benefit ranges from $63.50 to a maximum of $125 (5 times the $25 daily payment). The weekly maximum has been $125 since 1976. As a result of budget sequestration, unemployment and sickness benefits were reduced in parts of 1986 and 1987. The payments were later restored to previous levels with passage of budget legislation, and the 1987 restoration was retroactive.

The nominal average weekly amount in a benefit year has grown in spurts from $8 in 1940 to $125 in 1987. The average weekly benefit amount in constant 1986 dollars, however, declined by 45 percent, from a peak of $228 in 1976 to $125 in 1986. Moreover, the

1986 level was lower than the constant dollar level as long ago as 1958 when it was $149.

The program offers "normal" benefits and two categories of "extended" benefits. The duration of benefits varies by worker. Qualified workers can receive normal benefits for up to 130 days or 26 weeks, but the total may not exceed their creditable wages in the base year. Two groups of workers may get extended benefits:

(1) Workers with at least 15 years of railroad service may get up to 130 additional days, or up to an additional 26 weeks of benefits beyond the normal 26 weeks; and

(2) Workers with at least 10 but fewer than 15 years of railroad service may receive up to 65 additional days or 13 additional weeks.

TABLE 1.—PERMANENT BENEFITS UNDER THE RAILROAD UNEMPLOYMENT COMPENSATION PROGRAM AS OF DECEMBER 31, 1987

Qualifying wages	$1,500.
Daily benefit rate:	
Basic rate	60 percent of daily rate of pay.
Maximum	$25.00.
Minimum guarantee	$12.70.
Maximum normal benefits:	
For a 1-week period	$125.00.
For benefit year:	
Duration	130 compensable days.
Amount	$3,250.[1]
Maximum extended benefits:	
10–14 years service:	
Duration	65 compensable days.
Amount	$1,625.
15 or more years service:	
Duration	130 compensable days.
Amount	$3,250.

[1] Not to exceed the employee's taxable earnings in the base year counting earnings up to $775 a month.

Source: U.S. Railroad Retirement Board Handbook on Railroad Retirement and Unemployment Insurance Systems. January 1988.

The average duration of benefits fluctuates closely with the unemployment rate. In the 1940 through 1986 period, it ranged from 7.4 to 19.1 weeks and averaged 11.9.

In 1946, a program of cash sickness benefits was established for railroad workers as part of the unemployment compensation system. Sickness benefits are financed out of the same employer paid payroll taxes used to finance unemployment compensation benefits. A qualified railroad worker may receive sickness benefits if he files a "statement of sickness" signed by a doctor and mailed within 7 days of the first day for which a day of sickness is claimed.

A rail worker who is unemployed due to a strike legally authorized under the Railway Labor Act of 1926 can receive unemployment compensation benefits after a 14 day waiting period. Unemployment benefits cannot be paid to individuals participating in a strike that is in violation of the Railway Labor Act, and is therefore "illegal." Individuals who are unemployed due to an "illegal" strike, but who are not actually participating in the strike, are eligible for unemployment compensation benefits but are subject to the 14 day waiting period.

Total expenditures for unemployment and sickness payments were $174 million in benefit year 1987, which was 1.5 percent of total wages paid by the industry during the same period. This compares to a peak of 5.1 percent in 1959. It is also much lower than in benefit year 1983, a recession year, when the figure was 3.9 percent. Since the beginning of sickness benefits, unemployment benefits have composed about two-thirds of total payments. In 1987, unemployment benefits accounted for 68 percent of the total.

Benefit payments vary directly with the insured unemployment rate, covered employment, average weekly benefit amount, and average duration of benefits. The insured unemployment rate is the percentage of workers qualified under the RRUC program who drew benefits in a particular benefit year. The railroad insured unemployment rate has been high and volatile since the beginning of the RRUC program, averaging 14 percent. Since 1946 it has ranged from a relatively low 7 percent to 30 percent in benefit year 1983.

Changes in covered employment have short-run and long-run effects on the RRUC program. In the short run, when layoffs cause employment to decline, the insured unemployment rate and benefits paid increase. In the long run, when employers have fewer workers to layoff, benefits decline and the program shrinks. Since the peak of 1,680,000 workers in calendar year 1945, railroad employment declined to 316,000 in 1987. Two-thirds of this decline occurred in the 19 years between 1945 and 1964. In the 23 years since then, the remaining one-third of the decline occurred. In other words, the average annual decline through 1963 was 48,000, but after 1963 it was 20,000.

TAXES

The railroad unemployment and sickness benefit program is financed by payroll taxes paid by railroad employers. The employees themselves do not contribute. Effective January 1, 1984, the taxable earnings base is the first $600 of each employee's monthly earnings.

The payroll tax rate is determined from a schedule in the Railroad Unemployment Insurance Act and may vary from 0.5 percent to 8 percent. This method of financing is, in effect, an experience rating plan on an industrywide basis. For any particular calendar year, the tax rate depends on the balance in the Railroad Unemployment Insurance Account, including the balance in the Railroad Unemployment Insurance Administration Fund, on the preceding September 30, as shown in the following schedule:

Balance to credit of Railroad Unemployment Insurance Account on September 30	Rate for next calendar year (percent)
$300,000,000 or more	0.5
$200,000,000 or more but less than $300,000,000	4.0
$100,000,000 or more but less than $200,000,000	5.5
$50,000,000 or more but less than $100,000,000	7.0
Less than $50,000,000	8.0

Railroad unemployment taxes are collected by the Railroad Retirement Board. Of each year's tax receipts, an amount equal to 0.5 percent of taxable payroll is set aside for administration. Over the past several years, additional funds have been transferred from the Railroad Unemployment Insurance Account because low employment levels were not expected to generate sufficient funds to cover administrative costs. As a result, annual appropriations from general revenues for administration of the unemployment and sickness program are not required. Excess funds allocated but not needed for administration are transferred to the Railroad Unemployment Insurance Account at the end of each fiscal year.

The Railroad Unemployment Insurance and Railroad Unemployment Insurance Administration Accounts are part of the Federal Unemployment Trust Fund. This trust fund has 53 State UC program accounts, 4 Federal accounts, and the 2 railroad accounts.

Despite occasional increases in the tax rates and taxable wage base, taxes and reserves have not covered RRUC unemployment and sickness benefit payments in 20 of the last 28 years. The tax rate on taxable wages increased to 8 percent in 1977 and 1978; dropped to 7.0 percent in 1979 and to 5.5 percent in 1980; and rose to 8.0 percent in 1981 through 1987. The monthly taxable wage base was increased from $300 to $350 in 1954; to $400 in 1959 and to $600 in 1984. As a result, the taxable wage base in constant dollars had declined dramatically. The monthly taxable wage base would have been approximately $2,300 in 1986 if Congress had maintained the real value of the $300 taxable wage base in effect in 1940. In other words, the industry has taxed progressively less of total annual wages paid. The ratio of taxable wages to total wages had declined from 99 percent in 1940 to only 16 percent in 1983. This figure rose to 23 percent in 1984 and 1985 with the introduction of the higher taxable wage base and dropped to 22 percent in 1986.

Since 1959, the railroad unemployment trust fund has been able to borrow funds from the railroad pension fund when employer taxes have not been sufficient to cover the costs of unemployment and sickness benefits. This borrowing authority expired on December 19, 1985 but was subsequently restored by the April 1986 budget reconciliation legislation. In the past, borrowed funds have been repaid. The RRUC program became depleted for the first time in 1960 after a long decline from peak reserves of nearly 18 percent of total annual wages in 1948. By 1963, it owed the retirement account $314 million, or 5.9 percent of total annual wages paid in the industry that year. The program gradually recovered during the 1960s until it had positive reserves again in 1974. Thereafter, the reserves were depleted again in 1976 through 1978, and 1981 through 1986.

A rapid decline in 1981 and 1982 in railroad employment resulted in substantial borrowing from the pension system. In 1987, the RRUC program owed the railroad pension system $750 million. This is about 7 percent of total wages projected to be paid in the industry that year.

Prior to the passage of the Railroad Retirement Solvency Act of 1983 there were no specific requirements or procedures for the repayment of funds the RRUC system borrowed from the rail pension system. In general, loans had been repaid whenever, and to the extent, RRUC program tax receipts in a year exceeded that year's benefit, administration and debt service costs. In calendar year 1987, ad hoc loan repayments totaled $26.2 million.

The Solvency Act established, as part of the Federal Unemployment Tax Act (FUTA), a railroad unemployment repayment tax. This repayment tax operates similar to the FUTA tax that is paid by non-railroad industries in States with overdue Federal unemployment loans. Beginning July 1, 1986, rail employers paid this tax on annual wages paid to each employee through the end of the year. The tax base is $7,000 per employee for calendar years 1987–89, and $5,250 for the first 9 months of 1990. The April 1986 budget reconciliation legislation, which restored the authority to borrow funds from the Railroad Retirement Account, also increased the repayment tax rates originally set in the Solvency Act. The original 2 percent rate for 1986 was increased to 4.3 percent and the rates for 1987 and 1988 were increased to 4.7 percent and 6 percent, from 2.3 percent and 2.6 percent, respectively. The original rates of 2.9 percent for 1989 and 3.2 percent for 1990 were not changed. The revenue raised by this tax can be used only to repay loans (principal and interest) from the rail pension system made prior to September 30, 1985. Through the end of calendar year 1987, some $168 million had been collected. The tax expires on September 30, 1990, at which time the balance owed the rail pension system will be approximately $650 million.

The budget legislation also provided for an automatic unemployment insurance surtax on rail employers of 3.5 percent on annual wages up to $7,000 in the event further borrowing from the Railroad Retirement Account is necessary. The surtax will be in effect for a calendar year if any new unemployment insurance loans are not repaid with interest by the preceding September 30. There have been no new loans since November 1984, so the surtax has not yet been applied.

PART 3

REVENUES—SUMMARY INFORMATION

Revenues—Summary Information

This part provides summary information regarding Federal revenues and the U.S. tax system. Most, but not all, budget receipts are derived from taxes. Table 1 shows budget receipts, by source, for recent years. Table 2 indicates the relative significance of the major types of receipts. Over recent years the relative significance of corporate income taxes has declined; social insurance taxes and contributions have increased as a share of the total.

Table 3 provides information on the number of tax returns, by type filed in 1981 through 1985. The gross amount of taxes collected exceeds net collections by the amount of refunds. As indicated in table 4, individual income tax refunds during fiscal year 1987 were 16 percent of gross collections.

The sources of income reported on individual income tax returns for 1984 and 1985 are listed in table 5 along with additional summary information. More than 100 million individual income tax returns were filed for the 1985 taxable year. The number of exemptions listed on these returns, 244 million, approximately equaled the U.S. population, though the extra exemptions for those over 65, certain students, and the blind result in the double counting of certain individuals in arriving at the total number of exemptions claimed. Wages and salaries represented about 83 percent of reported adjusted gross income. Tax liabilities represented about 14 percent of adjusted gross income.

About 39 percent of all taxpayers itemized their deductions on individual income tax returns for 1985 (see table 6 for a comparison with prior years). These deductions, by type, are shown in table 7. Statutory adjustments used in calculating tax liabilities for 1984 are shown in table 8. Information on tax credits claimed by individuals for the same year is shown in table 9.

The distribution of tax liabilities and income by adjusted gross income class, based on information contained on 1984 tax returns, is displayed in table 10. Table 11 compares some advance data for 1986 with similar data for 1985.

The most recently published information for corporate income tax returns is summarized in table 12. Of the 3.2 million returns filed by regular, active corporations for 1984, only 31 percent had a tax liability, after accounting for tax credits and carryover losses. Fewer than 1 million corporations paid total taxes of 64.0 billion.

The term "tax expenditures" is widely used to denote the decrease in individual and corporate income tax liabilities that result from provisions in income tax laws and regulations that provide economic incentives to the private sector or tax relief to particular kinds of taxpayers. These tax provisions take the form of exclusions, credits, deductions, preferential tax rates, or deferrals of tax liability. Table 13 presents the most recent tax expenditure estimates for fiscal year 1987. For a more complete discussion of the tax expenditure concept, the source listed in the table should be consulted. The Tax Reform Act of 1986 significantly altered tax expenditures for future years both by repealing or otherwise altering particular provisions and by reducing tax rates.

TABLE 1.—BUDGET RECEIPTS BY SOURCE, 1979–87

[In billions of dollars]

Description	1979	1981	1983	1985	1987
RECEIPTS BY SOURCE					
Individual income taxes	217.8	285.9	288.9	334.5	392.6
Corporation income taxes	65.7	61.1	37.0	61.3	83.9
Social insurance taxes and contributions:					
Employment taxes and contributions	120.1	163.0	185.8	234.6	273.0
Unemployment insurance	15.4	15.8	18.8	25.8	25.6
Other retirement contributions	3.5	4.0	4.4	4.8	4.7
Total social insurance taxes and contributions	138.9	182.7	209.0	265.2	303.3
On-budget	(40.9)	(52.5)	(61.7)	(79.0)	(89.9)
Off-budget	(98.0)	(130.2)	(147.3)	(186.2)	(213.4)
Excise taxes:					
Alcohol	5.5	5.6	5.6	5.6	6.0
Tobacco	2.5	2.6	4.1	4.8	4.8
Highway	7.2	6.3	8.3	13.0	13.0
Airport and airway	1.5	*	2.2	2.9	3.1
Windfall profit tax		23.3	12.1	6.3	
Other	2.0	3.1	3.0	3.4	5.6
Total excise taxes	18.7	40.8	35.3	36.0	32.5
Estate and gift taxes	5.4	6.8	6.1	6.4	7.5
Customs duties	7.4	8.1	8.7	12.1	15.1
Miscellaneous receipts	9.3	13.8	15.6	18.5	19.3
Total receipts	463.3	599.3	600.6	734.1	854.1
On-budget	(365.3)	(469.1)	(453.2)	(547.9)	(640.7)
Off-budget	(98.0)	(130.2)	(147.3)	(186.2)	(213.4)

*$50 million or less.

Source: The United States Budget in Brief, Fiscal Year 1989, Executive Office of the President, Office of Management and Budget, p. 104.

TABLE 2.—BUDGET RECEIPTS BY SOURCE, 1979 AND 1987

	1979		1987	
	Amount (billions)	Percent of total	Amount (billions)	Percent of total
Individual income taxes	217.8	47.0	392.6	45.9
Corporation income taxes	65.7	14.2	83.9	9.8
Total social insurance taxes and contributions	138.9	30.0	303.3	35.5
Total excise taxes	18.7	4.0	32.5	3.8
Estate and gift taxes	5.4	1.2	7.5	0.9
Customs duties	7.4	1.6	15.1	1.8
Miscellaneous receipts	9.3	2.0	19.3	2.3
Total budget receipts	463.3	100.0	854.1	100.0

Source: The United States Budget in Brief, Fiscal Year 1989, Executive Office of the President, Office of Management and Budget, p. 104.

TABLE 3.—NUMBER OF RETURNS FILED, BY PRINCIPAL TYPE OF RETURN, CALENDAR YEARS 1982–86

[In thousands]

Type of return	1982	1983	1984	1985	1986
Income tax returns:					
Individual	95,481	95,284	96,288	99,426	102,393
Declaration of estimated tax	31,863	33,080	32,597	34,225	35,485
Fiduciary	1,964	1,994	2,013	2,053	2,305
Partnership	1,561	1,586	1,663	1,717	1,845
Corporation	2,950	3,078	3,129	3,303	3,667
Total income tax returns	133,819	135,022	135,690	140,724	145,696
Estate tax	135	111	90	77	72
Gift tax	99	91	87	95	103
Employment tax	25,835	25,537	26,133	26,824	27,921
Exempt organization	444	437	393	431	487
Employee plans	1,021	752	955	644	2,142
Alcohol, tobacco, and firearms	233	582	552	397	520
Excise tax	1,172	1,010	694	796	1,265
Supplemental documents	7,556	7,602	7,887	8,198	9,795
Non-Master file returns	55	30	32	33	17
Grand total	170,369	171,174	172,512	178,219	188,018

Source: Commissioner of Internal Revenue, Annual Report, 1982, 1983, 1985, and 1986.

TABLE 4.—INCOME TAX GROSS COLLECTIONS, REFUNDS, AND NET RECEIPTS, 1987

[In millions of dollars]

	Amount
Individual income tax:	
Gross collections	465,453
Withheld	(322,496)
Other	(142,957)
Refunds	−72,896
Net receipts	392,557
Corporation income taxes:	
Gross collections	102,663
Refunds	−18,933
Net receipts	83,730

Source: Executive Office of the President, Office of Management and Budget, Budget of the U.S. Government, Fiscal Year 1989, p. 6g–20.

TABLE 5.—INDIVIDUAL INCOME TAX—SOURCES OF INCOME AND SELECTED TAX ITEMS, 1984 AND 1985

[In billions of dollars except as noted]

Items	1984	1985 [1]
Number of returns, total (millions)	99.4	101.7
Taxable	81.6	83.1
Nontaxable	17.8	18.7
Number of exemptions (millions)	240.9	244.5
Adjusted gross income less deficit	2,139.9	2,321.9
Sources of income:		
Salaries and wages	1,807.1	1,937.9
Pensions and annuities in adjusted gross income	80.4	95.7
Business and profession net profit less loss	70.8	77.2
Farm net profit less loss	−13.1	−11.6
Partnership and S corporation: net profit less loss	−2.3	5.0
Sales of capital assets: net gain less loss	54.5	66.7
Dividends in adjusted gross income	48.6	55.4
Interest received	176.4	180.8
Rents and royalties: net income less loss	−9.5	−12.2
Total statutory adjustments	89.7	94.9
Total deductions	[2] 499.6	551.3
Total itemized deductions	358.9	401.0
Taxable income	1,701.4	1,832.6
Income tax before credits	306.7	336.1
Total credits	9.3	10.4
Income tax after credits	297.4	325.6

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[1] Preliminary data.

[2] Includes total itemized deductions, charitable contributions for nonitemizers, and zero bracket amount on nonitemized deductions.

Source: U.S. Department of the Treasury, IRS, Statistics of Income, Individual Income Tax Returns, 1984 and SOI Bulletin, Winter 1986–87.

TABLE 6.—INDIVIDUAL INCOME TAX RETURNS WITH ITEMIZED DEDUCTIONS, 1960–85

[In millions]

	Total individual returns[1]	Returns with itemized deductions	
		Number	Percent of total
1960	61.0	24.1	39.5
1965	67.6	27.9	41.3
1970	74.3	35.4	47.6
1972	77.6	27.0	34.8
1973	80.7	28.0	34.7
1974	83.3	29.6	35.5
1975	82.2	26.1	31.8
1976	84.7	26.0	30.7
1977	86.6	22.9	26.4
1978	89.9	25.8	28.7
1979	92.6	26.5	28.6
1980	93.6	28.8	30.8
1981	95.4	31.6	33.1
1982	94.8	33.2	35.0
1983	96.3	35.2	36.6
1984	99.4	38.2	38.4
1985	101.7	40.0	39.3

[1] Through 1970, excludes returns with no adjusted income; thereafter includes returns with no adjusted income.

Source: Statistical Abstract of the United States 1980, p. 269, and U.S. Department of Treasury, Internal Revenue Service, SOI Bulletin, Winter 1981–82, Statistics of Income, Individual Income Tax Returns, 1984, and SOI Bulletin, Winter 1986–87.

TABLE 7.—INDIVIDUAL INCOME TAX—ITEMIZED DEDUCTIONS BY TYPE, 1985

	Number of returns (millions)	Amount (billions)
Medical and dental	10.7	$22.6
Taxes paid	39.6	128.3
Contributions	36.2	48.0
Interest	36.3	177.0
Miscellaneous deductions	33.0	24.0
Net casualty or theft loss	.3	1.5
Total	39.3	401.0

Source: U.S. Department of the Treasury, Internal Revenue Service, SOI Bulletin, Winter 1986–87.

TABLE 8.—INDIVIDUAL INCOME TAX—STATUTORY ADJUSTMENTS BY TYPE, 1984

	Number of returns (millions)	Amount (billions)
Moving expenses	1.7	$4.4
Employee business expense	7.6	19.3
Payments to an IRA	15.2	35.4
Payments to a Keogh plan	.6	4.1
Forfeited interest penalty	.7	.2
Alimony paid	.7	3.9
Deduction for working married couple	24.1	22.4
Other	.1	.1
Total	37.0	89.7
Note: Contributions deduction for nonitemizers	22.9	1.1

Source: U.S. Treasury, Internal Revenue Service, Statistics of Income, Individual Income Tax Returns, 1984.

TABLE 9.—INDIVIDUAL INCOME TAX—TAX CREDITS BY TYPE, 1984

	Number of returns (millions)	Amount (billions)
Child care credit	7.5	$2.6
Earned income credit	2.3	.3
Credit for the elderly and disabled	.5	.1
Business credit	4.5	4.4
Foreign tax credit	.4	.7
Political contributions credit	5.1	.3
Residential energy credit	2.7	.6
Other credits	.1	.2
Total	20.5	9.3

Source: U.S. Treasury, Internal Revenue Service, Statistics of Income, Individual Income Tax Returns, 1984.

TABLE 10.—RETURNS, ITEMIZERS, ADJUSTED GROSS INCOME, AND TAX LIABILITIES, BY ADJUSTED GROSS INCOME CLASS, 1984

Adjusted gross income	Number of returns (millions)	Percentage itemizing deductions	Adjusted gross income		Total income tax [1]		Tax as a percent of adjusted gross income
			Billions	Percent	Billions	Percent	
No A.G.I	1.0	NA	−$33.3	−1.6	$0.4	0.1	NA
Below $5,000	16.2	4.4	43.2	2.0	.5	.2	1.1
$5,000 under $10,000	16.4	10.0	123.2	5.8	5.4	1.8	4.4
$10,000 under $15,000	14.1	18.9	174.3	8.1	12.8	4.2	7.3
$15,000 under $20,000	11.5	31.8	199.8	9.3	18.5	6.1	9.3
$20,000 under $30,000	16.4	54.4	407.2	19.0	45.8	15.2	11.2
$30,000 under $50,000	17.0	83.2	649.1	30.3	87.3	28.9	13.4
$50,000 under $100,000	5.7	94.9	364.3	17.0	66.1	21.9	18.1
$100,000 under $200,000	.8	98.3	100.0	4.7	25.8	8.5	25.8
$200,000 and above	.2	98.9	111.9	5.2	40.4	13.4	36.1
Total	99.4	38.4	2,139.9	100.0	301.9	100.0	14.1

[1] Tax liabilities do not reflect the refundable portion of the earned income credit.

Source: U.S. Department of the Treasury, Internal Revenue Service, Statistics of Income, Individual Income Tax Returns, 1984.

TABLE 11.—SELECTED SOURCES OF INCOME AND TAX ITEMS, FINAL 1985 AND PRELIMINARY 1986

[Dollars in millions]

Item	Statistics of income, 1985 (1)	Advance data, 1986 (2)	Change (3)	Percentage change (4)
Number of returns (in thousands)	101,660	103,300	1,640	1.61
Taxable	82,846	84,324	1,478	1.78
Nontaxable	18,814	18,975	161	.86
Number of exemptions (in thousands)	244,180	246,596	2,416	.99
Adjusted gross income less deficit	$2,305,951	$2,522,517	$216,566	9.39
Selected sources of income:				
Salaries and wages	1,928,201	2,046,135	117,934	6.12
Dividends in adjusted gross income	55,046	63,074	8,028	14.58
Interest received	182,109	168,202	−13,907	−7.64
Sales of capital assets net gain less loss (reported on Schedule D)	67,694	135,005	67,311	99.43
Total itemized deductions	405,024	446,542	41,518	10.25
Taxable income	1,820,741	1,976,812	156,071	8.57
Income tax before credits	332,165	378,422	46,257	13.93
Income tax after credits	321,917	370,932	49,015	15.23

Source: Internal Revenue Service, Statistics of Income Division, December 1987.

TABLE 12.—CORPORATION INCOME TAXES—RETURN CHARACTERISTICS OF ACTIVE CORPORATIONS, 1984

Item	Number of returns	Amount [1]
Returns With and Without Net Income		
Number of returns	3,170,743	....
Total receipts	3,040,991	7,860,711
Net income (less deficit)	3,150,979	232,901
Total income tax	1,234,473	107,968
Distribution to stockholders (except in own stock)	NA	144,872
Returns with net income	NA	130,101
Total assets	NA	11,106,702
Depreciable assets	NA	2,913,302
Depreciation deduction	NA	264,882
Returns With and Without Net Income, Other Than Forms 1120S and 1120–DISC [2]		
Number of returns	2,456,924	....
Total receipts	2,373,346	7,433,121
Net income (less deficit)	2,441,336	215,117
Statutory special deductions, total	505,992	36,326
Net operating loss deduction	397,887	25,996
Total special deductions	120,883	10,360
Income subject to tax, total	1,187,534	257,022
Net long-term capital gain taxed at alternative rates	34,551	20,214
Income taxed at regular rates	1,186,028	236,808
Income tax, total	1,230,464	107,935
Regular and alternative tax	1,187,533	106,002
Personal holding company tax	2,219	7,930
Tax from recomputing prior-year investment credit	184,083	1,368,601
Additional tax for tax preferences	8,133	544
Foreign tax credit	4,837	21,075
U.S. possessions tax credit	536	1,979
General business credit [3]	802,763	19,265
Research activities credit	10,132	1,589
Total income tax after credits	976,625	63,956

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[1] Amounts in millions of dollars.

[2] The income of firms that file form 1120S (subchapter S corporations) is taxed at the individual level. The income of firms that file form 1120–DISC (domestic international sales corporations) generally is not included in taxable income.

[3] Credits include investment, jobs, alcohol fuels, and employee stock ownership credits.

Note.—Details may not add to total because of rounding; 1984 data are for corporations with taxable years beginning July 1983 through June 1984.

Source: U.S. Department of the Treasury, Internal Revenue Service, Statistics of Income 1984. Corporation Income Tax Returns.

TABLE 13.—TAX EXPENDITURES BY FUNCTION, 1987

[In millions of dollars]

Description	Corporations	Individuals
National defense:		
Exclusion of benefits and allowances to Armed Forces personnel		2,000
International affairs:		
Exclusion of income earned abroad by U.S. citizens		1,330
Exclusion of income of foreign sales corporations (FSC)	770	
Inventory property sales source rules exception	1,845	
Certain nonfinancial institutions operations interest allocation rules exception	15	
Deferral of income from controlled foreign corporations	235	
General science, space, and technology:		
Expensing of research and development expenditures	565	20
Credit for increasing research activities	1,845	20
Suspension of the allocation of research and experimentation expenditures	270	
Energy:		
Expensing of exploration and development costs:		
Oil and gas	−1,100	425
Other fuels	35	
Excess of percentage over cost depletion:		
Oil and gas	145	580
Other fuels	200	15
Capital gains treatment of royalties on coal	5	45
Exclusion of interest on State and local industrial development bonds for certain energy facilities	305	
Residential energy credits:		
Supply incentives		45
Conservation incentives		*
Alternative, conservation and new technology credits:		
Supply incentives	140	10
Conservation incentives	*	*
Alternative fuel production credit	10	*
Alcohol fuel credit [1]	5	*
Energy credit for intercity buses	*	
Special rules for mining reclamation reserves	40	5
Natural resources and environment:		
Expensing of exploration and development costs, nonfuel minerals	30	5
Excess of percentage over cost depletion, nonfuel minerals	305	15
Exclusion of interest on State and local IDBs for pollution control and sewage and waste disposal facilities	1,715	
Tax incentives for preservation of historic structures	70	150
Capital gains treatment of iron ore	*	10
Capital gains treatment of certain timber income	145	60
Expensing of multiperiod timber growing costs	95	35

TABLE 13.—TAX EXPENDITURES BY FUNCTION, 1987—Continued

[In millions of dollars]

Description	Corporations	Individuals
Investment credit and seven-year amortization for reforestation expenditures	40	165
Agriculture:		
Expensing of certain capital outlays	65	425
Expensing of certain multiperiod production costs	*	*
Treatment of loans forgiven solvent farmers as if insolvent		10
Capital gains treatment of certain income	10	125
Special investment credit carryback rules for farming		
Commerce and housing credit:		
Dividend exclusion		350
Exclusion of interest on small issue industrial development bonds	2,925	
Exemption of credit union income	195	
Excess bad debt reserves of financial institutions	385	
Exclusion of interest on life insurance savings	315	5,110
Deduction for special percentage of taxable income for life insurance companies	290	
Deductibility of interest on consumer credit		11,845
Deductibility of mortgage interest on owner-occupied homes		34,745
Deductibility of property tax on owner-occupied homes		10,285
Exclusion of interest on State and local housing bonds for owner-occupied housing		2,010
Exclusion of interest on State and local debt for rental housing	1,385	
Capital gains (other than agriculture, timber, iron ore and coal)	910	61,285
Deferral of capital gains on home sales		2,575
Exclusion of capital gains on home sales for persons age 55 and over		2,160
Carryover basis of capital gains at death		5,710
Investment credit, other than ESOP's, rehabilitation of structures, energy property, and reforestation expenditures	11,505	1,800
Accelerated depreciation on rental housing	140	70
Accelerated depreciation of buildings other than rental housing	190	70
Accelerated depreciation of machinery and equipment	10,270	3,010
Safe harbor leasing rules	1,065	
Amortization of start-up costs	20	200
Reduced rates on the first $100,000 of corporate income	3,710	
Exception from passive loss rules for $25,000 of rental losses		350
Transportation:		
Deferral of tax on shipping companies	115	

TABLE 13.—TAX EXPENDITURES BY FUNCTION, 1987—Continued

[In millions of dollars]

Description	Corporations	Individuals
Exclusion of interest on State and local bonds for mass commuting vehicles	35	
Community and regional development:		
Five-year amortization for housing rehabilitation	15	30
Credit for low-income housing investments	*	30
Investment credit for rehabilitation of structures (other than historic)	145	130
Exclusion of interest on IDBs for airports, docks and sports and convention facilities	755	
Education, training, employment, and social services:		
Exclusion of scholarship and fellowship income		610
Exclusion of interest on State and local student loan bonds		400
Exclusion of interest on State and local debt for private nonprofit educational facilities		285
Parental personal exemption for students age 19 or over		560
Deductibility of charitable contributions (education)	450	1,270
Employer educational assistance		220
Exclusion of employer provided child care		30
Exclusion of employee meals and lodging (other than military)		745
Exclusion of contributions to prepaid legal services plan		75
Tax credit for ESOPs	665	
Credit for child and dependent care expenses		3,475
Targeted jobs credit	115	30
Deduction for two earner married couples		5,390
Deductibility of charitable contributions other than education and health	560	11,535
Deductions for certain adoption expenses		*
Exclusion of parsonage allowances		125
Health:		
Exclusion of employer contributions for medical insurance premiums and medical care		24,550
Deductibility of medical expenses		3,150
Exclusion of interest on State and local debt for private nonprofit health facilities		2,570
Deductibility of charitable contributions (health)	275	1,295
Tax credit for orphan drug research	*	
Social Security:		
Exclusion of untaxed Social Security benefits:		
Disability insurance benefits		1,170
OASI benefits for retired workers		14,285
Benefits for dependents and survivors		3,025
Income security:		
Exclusion of untaxed railroad retirement system benefits		400
Exclusion of workmen's compensation benefits		2,740
Exclusion of public assistance benefits		530
Exclusion of special benefits for disabled coal miners		135

TABLE 13.—TAX EXPENDITURES BY FUNCTION, 1987—Continued

[In millions of dollars]

Description	Corporations	Individuals
Exclusion of untaxed unemployment insurance benefits		690
Exclusion of military disability pensions		115
Net exclusion of pension contributions and earnings:		
Employer plans		45,335
Individual Retirement Accounts		13,890
Keoghs		2,355
Exclusion of other employee benefits:		
Premiums on group term life insurance		1,940
Premiums on accident and disability insurance		120
Income of trusts to finance supplementary unemployment benefits		30
Additional exemption for the blind		15
Additional deduction for the blind		10
Additional exemption for elderly		1,205
Additional deduction for the elderly		1,630
Tax credit for the elderly and disabled		180
Deductibility of casualty losses		285
Earned income credit [2]		525
Veterans benefits and services:		
Exclusion of veterans disability compensation		1,615
Exclusion of veterans pensions		130
Exclusion of GI bill benefits		90
Exclusion of interest on State and local debt for veterans housing		300
General government:		
Credits and deductions for political contributions		250
General purpose fiscal assistance:		
Exclusion of interest on public purpose State and local debt	2,070	8,810
Deductibility of nonbusiness State and local taxes other than on owner-occupied homes		22,480
Tax credit for corporations receiving income from doing business in United States possessions	1,895	
Interest:		
Deferral of interest on savings bonds		870

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*$2.5 million or less. All estimates have been rounded to the nearest $5 million.

[1] In addition, the exemption from the excise tax for alcohol fuels resulted in a reduction in excise tax receipts of $475 million in 1987.

[2] The figures in the table indicate the effect of the earned income tax credit on receipts. The effect on outlays in 1987 was $1,410 million.

Source: Executive Office of the President, Office of Management and Budget, Special Analysis, Budget of the United States Government, fiscal year 1989, pp. G 41–45.

PART 4

OTHER MATTERS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS

Section 1. Public Debt, Debt Management, and Interest Payments
Section 2. The Federal Financing Bank
Section 3. Pension Benefit Guaranty Corporation

Section 1. Public Debt, Debt Management, and Interest Payments

This section describes the relationship between changes in the public debt and the budget as well as the statutory limitations on the conduct of debt management. A variety of data descriptive of the public debt also is provided.

An increase in the gross public debt during a fiscal year is approximately equal to the Federal budget deficit plus trust fund surpluses under present budget conventions, as amended by the Balanced Budget and Emergency Deficit Control Act of 1985 (Public Law 99–177, the Gramm-Rudman-Hollings Act). Under the Act, the Federal Financing Bank and several other Federal entities which had been "off budget" under prior budget concepts were moved "on budget." The Act also changed the budgetary status of Social Security by excluding the operations of the old-age and survivors insurance trust fund (OASI) and the disability trust fund (DI) from the budget. Notwithstanding this provision, the Act provided that the receipts and disbursements of OASI and DI shall be included in calculating the deficit.

The Federal budget deficit is equal to the Federal funds deficit less the surplus in trust funds, both on-budget trust funds and the two off-budget trust funds. Federal funds receipts are derived mainly from taxes and are used for the general purposes of the Government. The trust funds collect certain taxes and other receipts for specified purposes, such as payment of Social Security benefits, in accordance with the terms of a trust agreement or statute. Thus, even if the budget were in balance, the public debt would still increase if the Federal funds were in a deficit position and the trust funds accumulated an offsetting surplus.

Because trust fund surpluses are invested in public debt securities, the increase in the gross public debt during a fiscal year approximates the deficit plus trust fund surpluses. An increase in the gross public debt is not precisely equal to the Federal deficit plus the trust fund surpluses because, to a limited extent, deficits can be financed by means other than borrowing. For example, if the Federal Government ends the fiscal year with a smaller cash balance than at the beginning of the year, that decline in the cash balance would substitute for borrowing from the public.

It is, of course, possible for the public debt to decline. For example, this would occur if a Federal funds deficit were less than trust fund surpluses and thus there was a budget surplus. Investment of trust fund surpluses in public debt securities would be accomplished by the Treasury not issuing new debt to replace maturing debt held by the public and instead issuing new special issues to the trust funds. In economic terms, the debt held by the public—that is the amount that excludes the debt held by trust funds—has much more significance than the total debt outstanding.

Table 1 provides actual information on the budget and public debt. This information is taken from the budget documents for fiscal year 1989. As a part of its budget proposals, the Administration recommends placing all the off-budget Federal entities on-budget. This would have the effect of increasing budget outlays and deficits but not affecting the debt subject to limit. Table 1 shows both outlay and deficit figures broken down by their on-budget and off-budget components.

Table 2 shows the statutory debt limit and debt subject to limit at the end of each fiscal year since 1977. The gross public debt is larger than the amount subject to limit primarily because certain debts issued by Federal agencies are not, by statute, subject to the debt ceiling. The amount of such agency debt outstanding has been reduced in recent years. For a more complete discussion of the budget and debt concepts see special analyses C and E in Special Analyses, Budget of the United States Government, Fiscal Year 1989.

Statutory limitations have traditionally been placed on Federal debt. Until World War I, the Congress ordinarily authorized a specific amount for each debt issue. Beginning with the Second Liberty Bond Act of 1917, however, the nature of the limitation was modified in several steps until it developed into a ceiling on the total amount of most Federal debt outstanding. The latter type of limitation has been in effect since 1941.

In 1971, the statutory debt limit was set at a permanent limit of $400 billion. Temporary increments that usually expired in a year or less were periodically enacted. Since the debt subject to limit was more than $400 billion, new legislation was required no later than the expiration date of each temporary increment. Several times in recent years the temporary increment expired without having been extended, so for a few days on each occasion the Federal debt exceeded the statutory limit. The validity of debt issued prior to the expiration of the temporary ceiling was not affected, but the Treasury Department had to suspend all sales of savings bonds and other debt securities until a new temporary ceiling was enacted.

The distinction between the permanent and temporary debt limit was eliminated by Public Law 98-34 (enacted May 26, 1983). The limit was most recently increased to $2,800 billion on September 29, 1987, as part of the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987 (Public Law 100-119), which revised the Gramm-Rudman-Hollings Act. The public debt subject to limit on January 29, 1988, was $2,443.7 billion.

Rules enacted in 1979 integrate the House's procedure for setting of the public debt limit with the congressional budget process. Under this procedure (House Rule XLIX), when the conference report on a budget resolution is adopted and specifies a public debt limit for a fiscal year which differs from the statutory limit in effect, the Enrolling Clerk of the House prepares a joint resolution which changes the current statutory public debt limit consistent with the level of public debt specified in the budget resolution. The vote by which the House agreed to the conference report on the budget resolution is deemed to have been a vote in favor of the joint resolution on the public debt. If there is no conference report, the House vote to adopt the budget resolution applies. The joint resolution is then sent to the Senate for legislative action. After final passage by both Houses, the joint resolution is transmitted to the President for his signature.

This procedure does not preclude changing the public debt limit at any time by passing a public debt limit bill that originates in the Committee on Ways and Means.

Table 3 provides information on the ownership of the public debt. Interest received on the public debt held by Federal Reserve Banks is in excess of the costs of operating those banks. Excess earnings of the Federal Reserve Banks are paid over to the Treasury and classified as miscellaneous budget receipts. During fiscal year 1987, these payments totaled $16.8 billion.

Table 4 shows the composition of interest-bearing public debt by kind of obligation. Current law constrains the composition of the debt by a 4¼ percent interest rate ceiling on bonds held by the public with a maturity at date of issue of 10 years or more. Under current law, $270 billion of long-term bonds are exempt from the 4¼ percent interest rate ceiling.

The maturity distribution of the debt is shown in table 5. This distribution can be summarized in terms of the average maturity of the debt. Debt management primarily involves decisions regarding the maturity composition of the debt. The longer the average maturity of the debt, the smaller the amount of maturing securities that must be refinanced with new issues at any one time. Smaller refunding operations are less likely to disturb capital markets. On the other hand, lengthening the average maturity of the debt requires issuing more longer term securities that are competitive with securities issued to finance private capital formation. Longer term securities typically carry higher interest rates than short-term securities so that lengthening the average maturity of the debt may result in higher interest payments.

Table 6 shows the growth of net interest payments by the Federal Government. In 1987, $195.2 billion of interest on the public debt was paid out. This was offset by interest received by trust funds, primarily the Social Security and civil service retirement funds, and other interest received. Included in this latter amount is interest earned by the Federal Financing Bank and, as a negative item, interest paid on refunds of tax collections. Net interest payments in 1987 were $138.6 billion, and 13.8 percent of total budget outlays.

TABLE 1.—RECEIPTS, OUTLAYS, AND DEBT, 1979–87

[In billions of dollars]

Description	1979	1981	1983	1985	1987
Receipts:					
On-budget:					
Federal	316.4	410.4	382.3	459.5	537.8
Trust funds	86.0	106.0	147.3	197.5	216.6
Interfund transactions	–37.0	–47.4	–76.4	–109.1	–113.7
Total on-budget	365.3	469.1	453.2	547.9	640.7
Off-budget (trust funds)	98.0	130.2	147.3	186.2	213.4
Total receipts	463.3	599.3	600.6	734.1	854.1
Outlays:					
On-budget:					
Federal funds	374.9	496.2	613.3	725.9	760.9
Trust funds	65.7	94.2	124.4	152.7	163.6
Interfund transactions	–37.0	–47.4	–76.4	–109.1	–113.7
Total on-budget	403.5	543.0	661.2	769.5	810.8
Off-budget (trust funds)	100.0	135.2	147.1	176.8	193.8
Total outlays	503.5	678.2	808.3	946.3	1,004.6
Surplus of deficit (–):					
Federal funds	–58.5	–85.8	–230.8	–266.4	–223.1
Trust funds	18.3	6.8	23.1	54.1	72.7
Total surplus or deficit (–)	–40.2	–78.9	–207.8	–212.3	–150.4
On-budget	(–38.2)	(–73.9)	(–208.0)	(–221.6)	(–170.0)
Off-budget	(–2.0)	(–5.0)	(0.2)	(9.4)	(19.6)
Debt outstanding, end of year:					
Gross Federal debt	833.8	1,003.9	1,381.9	1,827.5	2,355.3
Held by the public	644.6	794.4	1,141.8	1,509.9	1,897.8

Note.—For all years, transactions of the Social Security trust funds are presented off-budget and transactions of formerly off-budget accounts are presented on-budget.

Source: The United States Budget in Brief, Fiscal Year 1989, Executive Office of the President, Office of Management and Budget, p. 101.

TABLE 2.—STATUTORY DEBT LIMIT AND DEBT SUBJECT TO LIMIT, 1977–87

[In billions of dollars]

End of fiscal year	Statutory debt limit	Debt subject to limit
1977	700.0	700.0
1978	798.0	772.7
1979	830.0	827.6
1980	925.0	908.7
1981	999.8	999.8
1982	1,143.1	1,142.9
1983	1,389.0	1,378.0
1984	1,573.0	1,573.0
1985	1,823.8	1,823.8
1986	2,111.0	2,111.0
1987	2,800.0	2,336.0

Source: Treasury Bulletin, 4th Quarter, Fiscal 1987, p. 25, and earlier issues.

TABLE 3.—ESTIMATED OWNERSHIP OF PUBLIC DEBT SECURITIES, 1977–87

[Par. values; [1] billions of dollars]

End of calendar year	Total public debt securities	Held by Government accounts	Held by Federal Reserve Banks	Held by private investors											
				Total	Commercial banks [2]	Nonbank investors									
						Total	Individuals [3]			Insurance companies	Money market funds	Corporations [5]	State and local governments [6]	Foreign and international [7]	Other investors [8]
							Total	Savings bonds [4]	Other securities						
1977	718.9	154.8	102.8	461.3	98.9	362.4	107.8	76.7	31.1	19.9	.9	18.2	58.1	109.6	47.9
1978	789.2	170.0	110.6	508.6	95.0	413.6	114.0	80.7	33.3	20.0	1.5	17.3	76.1	133.1	51.6
1979	845.1	187.1	117.5	540.5	88.1	452.4	118.0	79.9	38.1	21.4	5.6	17.0	81.7	119.0	89.7
1980	930.2	192.5	121.3	616.4	112.1	504.3	117.1	72.5	44.6	24.0	3.5	19.3	87.9	129.7	122.8
1981	1,028.7	203.3	131.0	694.5	111.4	583.1	110.8	68.1	42.7	29.0	21.5	17.9	96.8	136.6	170.5
1982	1,197.1	209.4	139.3	848.4	131.4	717.0	116.5	68.3	48.2	39.1	42.6	24.5	116.6	149.5	228.2
1983	1,410.7	236.3	151.9	1,022.6	188.8	883.7	133.4	71.5	61.9	56.7	22.8	39.7	150.5	166.3	264.4
1984	1,663.0	289.6	160.9	1,212.5	183.4	1,029.1	143.8	74.5	69.3	76.4	25.9	50.1	173.4	192.9	366.6
1985	1,945.9	348.9	181.3	1,417.2	192.2	1,225.0	154.8	79.8	75.0	95.8	25.1	59.0	235.8	212.5	442.0
1986	2,216.4	403.1	211.3	1,602.0	230.1	1,371.9	162.9	92.3	70.5	106.9	28.6	68.8	273.1	251.5	486.0
1987 [9]	2,351.7	457.2	211.9	1,682.6	[10] 250.5	1,432.1	168.9	98.5	70.4	NA	NA	[10] 80.2	NA	[10] 268.4	NA

NA—Not available.

[1] U.S. savings bonds, series A–F and J, are included at current redemption value.

[2] includes domestically chartered banks, U.S. branches and agencies of foreign banks; New York investment companies majority owned by foreign banks, and Edge Act corporations owned by domestically chartered and foreign banks. [3] Includes partnerships and personal trust accounts.

[4] Includes U.S. savings notes. Sales began May 1, 1967, and were discontinued June 30, 1970. [5] Exclusive of banks and insurance companies.

[6] Includes State and local pension funds. [7] Consists of the investment of foreign balances and international accounts in the United States.

[8] Includes savings and loan associations, credit unions, nonprofit institutions, mutual savings banks, corporate pension trust funds, dealers and brokers, certain Government deposit accounts, and Government-sponsored agencies. [9] September estimate. [10] Preliminary data.

Source: Treasury Bulletin 4th Quarter, Fiscal 1987, p. 44.

TABLE 4.—INTEREST-BEARING PUBLIC DEBT SECURITIES BY KIND OF OBLIGATION, 1977–87

[In billions of dollars]

End of fiscal year	Total interest-bearing public debt securities	Marketable				Nonmarketable				
		Total	Treasury bills	Treasury notes	Treasury bonds [1]	Total	U.S. savings bonds	Foreign government and public series [2]	Government account series	Other [3]
1977	697.6	443.5	156.1	241.7	45.7	254.1	75.4	21.8	140.1	16.8
1978	767.0	485.2	161.0	267.9	56.4	281.8	79.8	21.7	153.3	27.1
1979	819.0	506.7	161.4	274.2	71.1	312.3	80.4	28.1	176.4	27.4
1980	906.4	594.5	199.8	310.9	83.8	311.9	72.7	25.2	189.8	24.2
1981	996.5	683.2	223.4	363.6	96.2	313.3	68.0	20.5	201.1	23.7
1982	1,140.9	824.4	277.9	442.9	103.6	316.5	67.3	14.7	210.5	24.1
1983	1,375.8	1,024.0	340.7	557.5	125.7	351.8	70.0	11.4	234.7	35.5
1984	1,559.6	1,176.6	356.8	661.7	158.1	383.0	72.8	8.8	259.5	41.8
1985	1,821.0	1,360.2	384.2	776.4	199.5	460.8	77.0	6.6	313.9	63.2
1986	2,122.7	1,564.3	410.7	896.9	241.7	558.4	85.6	4.1	365.9	102.8
1987	2,347.8	1,676.0	378.3	1,005.1	277.6	671.8	97.0	4.4	440.7	129.0

[1] Includes Treasury bonds and minor amounts of Panama Canal and postal savings bonds.

[2] Nonmarketable certificates of indebtedness, notes, bonds, and bills in the Treasury foreign series of dollar-denominated and foreign-currency denominated issues.

[3] Includes depository bonds, retirement plan bonds, Rural Electrification Administration bonds, State and local bonds, and special issues held only by U.S. Government agencies and trust funds and the Federal home loan banks.

Source: Treasury Bulletin, 4th Quarter, Fiscal 1987, p. 22, and prior issues.

TABLE 5.—MATURITY DISTRIBUTION AND AVERAGE LENGTH OF MARKETABLE INTEREST-BEARING PUBLIC DEBT SECURITIES HELD BY PRIVATE INVESTORS, 1977–1987

[Dollars in billions]

End of fiscal year	Amount outstanding, privately held	Maturity class					Average length	
		Within 1 year	1 to 5 years	5 to 10 years	10 to 20 years	20 years and over	Years	Months
1977	326.7	161.3	113.3	33.1	8.4	10.5	2	11
1978	356.1	163.9	133.0	33.5	11.4	14.8	3	3
1979	380.5	181.9	127.6	32.3	18.5	20.3	3	7
1980	463.7	220.1	156.2	38.8	25.9	22.7	3	9
1981	549.9	256.2	182.2	48.7	32.6	30.1	4	0
1982	682.0	314.4	221.8	75.7	33.0	37.1	3	11
1983	862.6	379.6	295.0	99.2	40.8	48.1	4	1
1984	1,017.5	437.9	332.8	130.4	49.7	66.7	4	6
1985	1,185.7	472.8	402.8	159.4	62.9	88.0	4	11
1986	1,354.3	506.9	467.3	190.0	70.7	119.4	5	3
1987	1,445.4	483.6	526.7	209.1	72.9	153.0	5	9

Note.—All issues classified to final maturity.

Source: Treasury Bulletin, 4th Quarter, Fiscal 1987, p. 25, and prior issues.

TABLE 6.—INTEREST PAYMENTS, 1979–1987

[In billions of dollars]

	1979	1981	1983	1985	1987
Interest on the public debt	59.8	95.5	128.6	178.8	195.2
Interest received by on-budget trust funds	−7.7	−11.5	−15.3	−21.8	−29.7
Interest received by off-budget trust funds	−2.2	−2.3	−1.8	−4.1	−5.3
Other interest	−7.3	−13.0	−21.7	−23.4	−21.7
Total net interest	42.6	68.7	89.8	129.4	138.6
On-budget	(44.8)	(71.0)	(91.6)	(133.5)	(143.9)
Off-budget	(−2.2)	(−2.3)	(−1.8)	(−4.1)	(−5.3)

Source: Executive Office of the President, Office of Management and Budget, The United States Budget in Brief, Fiscal year 1989, pp. 110–111.

Section 2. The Federal Financing Bank

LEGISLATIVE HISTORY

The Federal Financing Bank (FFB) was established by Public Law 93-224 after favorable consideration by the House Committee on Ways and Means and the Senate Committee on Banking, Housing and Urban Affairs. The House and Senate agreed to the conference report on December 19, 1973. (House Reports 93-299, Committee on Ways and Means and 93-700, Conference Committee, and Senate Report 93-166, Committee on Banking). The Balanced Budget and Emergency Deficit Control Act of 1985 (Public Law 99-177) modified the Federal budgetary treatment of FFB's operations.

OPERATIONS OF THE FFB

The FFB was created as an off-budget Federal agency in the Treasury Department as a means for the efficient financing of obligations issued, sold or guaranteed by the Federal Government. Before the establishment of the FFB, Federal agencies generally financed their lending and loan guarantee programs by selling their own obligations to the public. This practice resulted in inefficiently high Federal borrowing costs. Agency obligations trade at premiums above Treasury securities because of their relative illiquidity, smaller size of issue, and unique financial terms. Accordingly, the FFB was authorized to: (1) purchase guaranteed loan assets from Federal agencies; (2) disburse directly to borrower's loans that are guaranteed by a Federal agency; and (3) purchase the debt of Federal agencies. The FFB began operations in May 1974. In order to finance its activities, the FFB was authorized to borrow in its own name in the private markets, but it has done so only once. Since then, the FFB has borrowed directly from the Treasury Department, and Treasury in turn has borrowed that amount in addition to the borrowing needed to finance the budget deficit. Hence, the Federal debt is increased as the Treasury Department borrows to accommodate the FFB.

The FFB's outstanding holdings grew from $35 billion in fiscal year 1977 to $107.8 billion in fiscal year 1981, and $157.3 billion in 1987. Much of the growth since 1977 occurred in the purchase of federally guaranteed loans.

Under the unified Federal budget, disbursements of loans by Federal agencies are treated as outlays of the agency originating the transaction. However, before fiscal year 1987, agency lending activity was effectively converted to off-budget status when the FFB (itself off-budget by statute) either purchased the loan asset from the originating Federal agency, or disbursed federally guaranteed loans directly to the borrower. As a result of FFB's activities, Federal outlays (and the deficit) were understated in the Federal budget. Under section 214 of the Emergency Deficit Control Act of 1985, however, FFB purchases of loan guarantees and disbursements of guaranteed loans are treated as outlays of the originating agency effective for fiscal year 1987. Accordingly, FFB activities have been incorporated into the accounts of each agency originating the respective transaction financed by the FFB, and are included in Federal budget totals.

There is no statutory limit on the magnitude of the FFB's operations. Accordingly, the only controls are indirect and result from whatever limits may be imposed in the authorizations or appropriations processes on the credit activities of other Federal agencies. Since 1980, the Administration and Congress have been working to develop a more comprehensive system for controlling Federal credit activities in the budget process. The Administration proposes appropriations limits on new direct loan obligations and loan guarantee commitments as part of the budget process. These requests are then acted upon by Congress through regular appropriations bills. Presently, limits have been proposed for more than half the Federal credit budget.

Recent and Prospective FFB Activity

The growth in new acquisitions and net lending on the part of the FFB came to a virtual halt in 1986, and these activities are projected to decline over the next few years. This is attributable to (1) a decline in Federal lending and loan guarantee programs; (2) the sale of loan assets by the FFB to the public; and (3) the prepayment of certain loans as authorized in recent legislation.

The Omnibus Budget Reconciliation Act of 1986 authorized certain rural electric cooperatives to prepay their Rural Electric Administration guaranteed loans held by the FFB without premium or penalty, and provided that prepayments in excess of $2,017.5 million during 1987 were to be subject to the approval of the Secretary of the Treasury. Under this legislation, rural electric borrowers prepaid $589 million in principal. The Omnibus Budget Reconciliation Act of 1987 authorized an additional $2 billion in premium-free prepayments during 1988, and the Continuing Appropriations Resolution of 1988 permits borrowers under the Foreign Military Sales program to prepay at par any debt with an interest rate of 10 percent or higher.

Outlays and Acquisitions

Table 1 illustrates that FFB annual outlays (net lending) grew from $14.4 billion in fiscal year 1980 to $21 billion in fiscal year 1981, and declined to $0.4 billion by fiscal year 1987. Over the same period, the FFB's outstanding portfolio has grown from $83 billion to $157 billion. New acquisitions have fallen from $20.2 billion in fiscal year 1980 to a projected $2.0 billion in fiscal year 1993.

TABLE 1.—FEDERAL FINANCING BANK ACTIVITIES

[In billions of dollars]

	Fiscal year—						
	1980	1981	1985	1986	1987	1989 [2]	1993 [2]
New acquisitions	22.2	30.3	18.3	11.6	7.0	4.4	2.0
Net lending	14.4	20.9	7.3	3.4	0.4	−10.5	−7.1
Loans outstanding [1]	83.1	107.8	153.5	156.9	157.3	132.7	103.1

[1] Includes balance of direct loans and purchases of Federal agency debt.

[2] Estimated.

Source: Various Special Analysis, Special Analysis F, Budget of the United States.

Section 3. Pension Benefit Guaranty Corporation

LEGISLATIVE HISTORY

The Pension Benefit Guaranty Corporation (PBGC) was established under Title IV of the Employee Retirement Income Security Act of 1974 (ERISA) (88 Stat. 829, Public Law 93-406) to protect the retirement income of plan participants and their beneficiaries covered under private sector defined benefit pension plans. Public Law 96-364 requires that the PBGC's receipts and disbursements are to be on-budget and included in the Government's budget totals. Since ERISA, major legislation affecting the PBGC has included: The Multiemployer Pension Plan Amendment Act of 1980 (P.L. 96-364); the Single Employer Pension Plan Amendment Act of 1985 (P.L. 99-272); and the Pension Protection Act of 1987 (P.L. 100-123).

EXPLANATION OF THE CORPORATION AND ITS FUNCTIONS

Administration

The Pension Benefit Guaranty Corporation is a wholly owned Government corporation, administered by a board of directors, the chairman being the Secretary of Labor; other directors being the Secretary of Commerce and the Secretary of the Treasury. ERISA provides for a 7-member Advisory Committee, appointed by the President, for staggered 3-year terms. The Advisory Committee is to advise the PBGC as to its policies and procedures relating to the appointment of trustees in termination proceedings, investment of moneys, plan liquidations, and other matters as requested by the PBGC.

Plan Termination Insurance Generally

The PBGC's insurance program under title IV of ERISA insures the pension benefits of about 38 million individuals through two insurance programs. These generally cover pension plans that are qualified under the Internal Revenue Code. One program insures plans sponsored by a single employer, or by a group of employers if the plan is not collectively bargained (single employer plans). The other program covers collectively bargained plans that are sponsored jointly by more than one employer and by a labor union (multiemployer plans). Only vested benefits are insured. Pension plans specifically excluded from the plan termination insurance program are government and church plans, individual account plans (i.e., defined contribution plans such as profit-sharing, money purchase, thrift and savings, and stock bonus plans), and plans of fraternal societies financed entirely by member contributions.

A. Single Employer Plans

Terminated single employer plans with assets insufficient to pay guaranteed benefits are taken over by the PBGC and a trust fund is established for plans taken into trusteeship. The PBGC assumes control of the plan assets and takes responsibility for the expected plan liability. The trust pays the share of benefit payments actually funded by plan assets and any claims recovered from the employer. The balance of guaranteed benefits is paid by the revolving funds.

Pension benefits for vested employees under defined benefit plans are guaranteed by the PBGC. The limitation on insured benefits under single-employer plans is the lesser of 100 percent of the employee's wages or $1,909.09 a month. The dollar amount is adjusted annually to reflect changes in the Social Security contribution and benefit base. In addition, benefits that have been in effect less than 5 years are not fully guaranteed.

B. Multi-Employer Plans

For multiemployer pension plans, the PBGC insures plan insolvency rather than plan termination. Financially troubled multiemployer plans may reorganize and adjust benefits under regulations of the PBGC which may extend loans to enable the plans to continue paying benefits.

Different benefit guarantee levels exist for participants in multiemployer pension plans. As a result of the Multiemployer Pension Plan Amendments Act of 1980 (Public Law 96-364), only the first $5 of the monthly benefit accrual rate is 100 percent guaranteed for each year of a participant's service, and 75 percent of the next $15 of the basic monthly benefits is guaranteed. (The 75 percent guaranty is reduced to 65 percent for plans that do not meet specified funding requirements.)

Financing

The PBGC is required by ERISA to be self-supporting. Sources of financing are insurance premiums from on-going defined benefit pension plans, assets from terminated plans, investment income and employer liability. The PBGC's insurance premium for single employer plans is set by statute. The PBGC may increase the premium rate for multiemployer plans up to certain limits imposed by law. The financial structure of PBGC's programs includes both revolving and trust funds, borrowing authority, and other sources of income.

A. Revolving Funds

Four revolving funds are employed to insure basic and non-basic pension plan benefits. One fund is used in connection with the basic benefits and contingent liability insurance programs related to single employer plans. A second fund is used in connection with the basic benefits and contingent liability insurance programs related to multiemployer plans. A third fund is associated with non-basic benefits insurance programs related to single employer plans. A similar fund, the fourth revolving fund, is used in connection with non-basic benefits insurance programs for multiemployer plans.

B. Trust Funds

(1) *Plan Assets.* The assets of plans for which PBGC has become trustee are the primary source of funding for the trust fund.

(2) *Employer Liability.* An employer's liability to the PBGC following plan termination depends on the kind of termination undertaken. Only two kinds of plan terminations are permitted under present law: standard and distress. An employer may not make a standard termination unless assets in the plan are sufficient to cover a plan's benefit liability (a plan's benefit liability is equal to all benefits owable on termination, including benefits contingent on unpredictable events which have not yet occurred, such as plant closings). Following a standard termination, an employer has no liability to either the PBGC or plan participants.

An employer may terminate a plan, the assets of which are less than benefit liability, only if the employer meets certain criteria of financial distress. These criteria include chapter 7 bankruptcy or an inability to pay debts when due in the absence of the plan termination. Following a distress termination of an underfunded plan, an employer and every member of the employer's controlled group remains jointly and severally liable to the PBGC for unfunded benefits up to the full amount of unfunded guaranteed benefits. Until the enactment of the Pension Protection Act of 1987 (P.L. 100–123), the employer and every member of the employer's controlled group was liable to the PBGC for unfunded guaranteed benefits up to a maximum amount equal to the sum of (1) 30 percent of the collective net worth of all persons subject to the liability; plus (2) 75 percent of unfunded guaranteed benefits in excess of the amount described in (1); plus (3) interest on the amount due calculated from the date of plan termination.

The total amount of unfunded guaranteed benefits is computed by treating any accumulated funding deficiency and the balance of any waived funding deficiency as a receivable of the plan and thus as a plan asset.

In a distress termination, the employer is liable to plan participants for the difference between benefit liabilities that cannot be paid out of plan assets and guaranteed benefits.

(3) *Investment Income.* Assets of plans and employer liability collections are invested in a diversified portfolio of private and public sector securities to realize the highest possible rate of return consistent with an appropriate level of risk for the type of program administered.

C. Sources of Income

(1) *Insurance Premiums.* The principal source of revenue for the plan termination insurance program are premiums required to be paid by ongoing covered plans. Before 1988, the annual premium for each participant in a single employer plan was $8.50. For plan years beginning after December 31, 1987, the basic per participant premium is set by statute at $16. An additional premium is also charged equal to $6 per $1,000 of unfunded vested benefits in the plan divided by the number of plan participants, up to $34 per par-

ticipant. The maximum annual per participant premium is thus $50.

D. Borrowing Authority

In addition to the premium and investment incomes which are generated for the revolving funds, the PBGC is authorized to borrow up to $100 million from the United States Treasury to carry out its responsibilities.

RECENT LEGISLATION AFFECTING SINGLE EMPLOYER PLANS

Since its inception, the single employer plan pension insurance program maintained by the PBGC has operated at a deficit. That is, the cost of purchasing annuities sufficient to pay the unfunded obligations in terminated underfunded plans has exceeded the value of PBGC's current assets, including premiums paid by ongoing plans, and recovered claims on the assets of employers with terminated plans. Congress has responded with two major pieces of legislation.

Single Employer Pension Plan Amendments Act of 1985

As of September 30, 1985, the program reported a deficit of $1.3 billion (liabilities of $2.7 billion minus assets of $1.4 billion) including a liability for a pending claim of over $400 million for plans that were later terminated by the Wheeling Pittsburgh Steel Corp. in November 1985. The 99th Congress addressed PBGC's mounting deficit with the Single Employer Pension Plan Amendments Act of 1985 (SEPPAA) which was included as title XI of the Consolidated Omnibus Budget Reconciliation Act of 1985. SEPPAA increased the annual per participant premium paid by employers from $2.60 to $8.50. SEPPAA also included a set of reforms, of which two were the most significant.

First, SEPPAA provided that an underfunded plan may be terminated voluntarily only if its sponsor (and certain members of the sponsor's controlled group) meets certain statutory standards of financial distress. After SEPPAA, employers have not been able to terminate underfunded plans merely because their net worth (and hence, PBGC's claims against the employer) is low. Second, SEPPAA increased an employer's liability to the PBGC following the termination of an underfunded plan. Under prior law, the employer's liability to the PBGC was capped at 30 percent of the employer's net worth. Under SEPPAA the 30 percent of net worth cap was calculated by looking at the net worth of every member of the employer's controlled group. Every member was made jointly and severally liable for this amount, plus 75 percent of unfunded guaranteed benefits in excess of this amount; plus interest on such amounts accrued since the date of plan termination.

However, these reforms failed to address important problems in the defined benefit pension guarantee system. Even before enactment of SEPPAA, PBGC's largest claims would have met the bill's criteria of distress. And while PBGC's claim against the employer was increased, the claim's low status in bankruptcy threatened on such amounts recovery in a significant number of cases.

Pension Protection Act of 1987

By the beginning of 1987, it was becoming increasingly apparent that the reforms implemented under SEPPAA were inadequate to ensure the long term solvency of the PBGC. By September 1987, PBGC's deficit had grown to $3.7 billion, up from $1.3 billion as of September 30, 1985. This increase in liability was largely attributable to a rash of plan terminations among steel industry corporations filing for bankruptcy. The most significant of these were four plans terminated by LTV Corp. totaling $2.2 billion of unfunded liability. Kathleen Utgoff, Executive Director of the PBGC, testified before the committee that under present law, PBGC's revolving fund was estimated to become insolvent by fiscal year 1989. If future terminations followed the experience shown in the past (in which on average the assets of terminated plans were sufficient to cover 40 percent of claims), Utgoff estimated that PBGC would be totally insolvent by the year 2003. (Hearings before the Subcommittee on Oversight of the Committee on Ways and Means, April 7, 1987, page 115. Hereinafter, "April 7 hearing"). In a report submitted to the Oversight Subcommittee, the General Accounting Office estimated that PBGC's *existing* deficit could be amortized over a 15-year period only with annual premium income of $446 million. Annual premium income was then projected to raise only $298 million, or 67 percent of the required amount. ("Pension Plans: Government Insurance Programs Threatened by its Growing Deficit," Subcommittee on Oversight, Committee on Ways and Means, House of Representatives, March 1987. Hereinafter, "March 1987 GAO report").

PBGC's testimony submitted for the April 7, 1987, hearing concluded that two factors were most significant in contributing to PBGC's long term projected deficit. First, the funding standards under Internal Revenue Code section 412, requiring minimum contributions to defined benefit pension plans, were inadequate. Second, PBGC's claim against an employer's assets in bankruptcy were too low. (Up to 30 percent of the collective net worth of the employer plus certain members of the employer's controlled group, PBGC's claim has the status of a tax lien; that is, it is senior to the claims of an employer's unsecured creditors, and junior to the claims of all the employer's secured creditors).

In a study of 23 employers who terminated 33 plans between 1983 and 1985, GAO reached similar conclusions in its March 1987 report. (These employers accounted for $451 million of claims, or 90 percent of PBGC's total claims over the period.) GAO found that 70 percent of these claims resulted from inadequacies in the standards setting required minimum contributions to defined benefit plans. The remaining 30 percent of claims were attributable to contributions that were required, but not paid before the plan was terminated. These claims were unpaid for a variety of reasons. About 23 percent of the unpaid claims were attributable to contributions that had been waived by the IRS. Another 45 percent had not yet fallen due, largely because the law permitted employers to make no contributions until as late as 8½ months after the close of the plan year. The remaining 32 percent were not waived, but were overdue and unpaid at the time of plan termination.

In February 1987, the administration submitted to the Congress its "Proposal on the Funding and Termination of Defined Benefit Pension Plans." The proposal had several major components, notably:

(1) A variable rate premium, based on three factors: (a) the ratio of plan assets to vested benefits under the plan; (b) the existence of outstanding funding waivers; and (c) the plan's ability to satisfy the minimum funding standards during the year;

(2) Strengthened minimum funding standards;

(3) Increased employer liability to the PBGC and plan participants following termination of an underfunded plan; and

(4) Employer access to the assets of an overfunded plan without terminating the plan.

Working with the administration, four committees of the Congress each reported a bill responding to the deteriorating financial condition of the PBGC: The Committee on Ways and Means, the Senate Finance Committee, the House Committee on Education and Labor, and the Senate Committee on Labor and Human Resources. The conference agreement among these four committees was entitled the Pension Protection Act of 1987, included in title IX of the Omnibus Budget Reconciliation Act of 1987, and enacted into law on December 22, 1987 (P.L. 100-203).

Significant reforms made by the act include the following provisions:

1. *Variable rate premium.*—The act increases the flat-rate per participant premium to $16. An additional premium is provided equal to $6 per $1,000 of unfunded vested benefits (divided by the number of participants), with a total additional per participant premium of $34. The maximum total per participant premium under the act is $50.

2. *Modification of minimum funding standards.*—The funding standards of prior law continue to apply to plans with assets equal to or greater than 100 percent of the plan's "current liability." Generally, current liability is the value of all liabilities to beneficiaries and participants under the plan determined as if the plan were terminated, but does not include the value of any benefits contingent on unpredictable events, such as plant closings. For plans with assets less than current liability, special rules apply designed to ensure that the employer funds the plan more rapidly than under prior law. The purpose of the rules is to ensure that as many plans as possible have assets equal to or approaching the level necessary to fund any benefits payable if the plan is terminated (other than unpredictable contingent event liabilities). In addition, a special rule requires faster funding of benefits contingent on unpredictable events once such an event occurs. This special rule is phased in until it is fully effective in 2001.

3. *Time for contributions.*—The act provides that contributions are due in four annual installments during the plan year, with a final contribution due 8½ months after the close of the plan year. In the case of plans with assets of less than 100 percent of current liability, failure to make a quarterly installment may give rise to a statutory lien on the employer's assets.

4. *Funding waivers.*—The act clarifies that a waiver can be granted only if the hardship is temporary in nature, and if the entire controlled group of which the employer is a member is experiencing the hardship. In addition, the number of waivers an employer may receive in a 15-year period is reduced to three, and certain other restrictions apply.

5. *Standards for termination.*—

(a) *Standard termination.*—An employer may terminate a plan in a standard termination only if the plan has assets sufficient to fund benefit liabilities which include all fixed and contingent benefits.

(b) *Distress termination.*—An employer may not terminate a plan with assets insufficient to fund benefit liabilities unless the employer and every member of the employer's controlled group meets the criteria of financial distress. In addition, in the case of a chapter 11 reorganization, a distress termination is unavailable unless the bankruptcy court determines the employer will otherwise be unable to pay its debts under the reorganization plan.

6. *Employer liability.*—

(a) *Employer liability to participants.*—The employer's liability to participants is increased to the full amount of benefit liabilities in excess of guaranteed benefits, whether following a standard or distress termination.

(b) *Employer liability to the PBGC.*—The employer's liability to the PBGC following a distress termination is increased to the full amount of guaranteed benefits. This liability is paid to the PBGC, which then pays benefits to participants and beneficiaries.

The following tables show the status of the PBGC's insurance programs and its financial condition. In budgetary terms, PBGC outlays are basically benefit obligations minus income to the funds. As long as this income exceeds the amount of benefit obligations, outlays are presented as a negative figure.

TABLE 1.—CURRENT FINANCING AND OUTLAYS OF THE PBGC

[In millions]

	1986 actual	1987 actual	1988 estimate	1989 estimate
Obligations:				
Benefit payments	238.8	471.2	353.4	420.4
Other	33.3	37.4	39.6	56.0
Total	272.1	508.6	393.0	476.4
Financing:				
Premium income	216.1	284.4	515.3	679.5
Benefit payment reimbursement	79.1	306.4	178.4	191.4
Other (primarily interest)	48.7	46.0	86.0	117.8
Total	343.9	636.8	779.7	988.7
Outlays as shown in Federal budget	−105.9	−72.0	−571.3	−504.5

Source: Fiscal year 1989 Budget of the United States, appendix.

TABLE 2.—FINANCIAL CONDITION OF FUNDS

[In millions]

	1985 actual	1986 actual	1987 actual	1988 estimate	1989 estimate
Assets	346.4	501.8	589.1	1,074.4	1,578.8
Liabilities	1,644.9	2,820.7	1,965.0	2,666.2	3,010.0
Government equity	−1,298.5	−2,318.9	−1,375.9	−1,591.7	−1,431.2

Source: Fiscal year 1989 Budget of the United States, appendix.

The following table provides information on terminated plans and trusteeships.

TABLE 3.—PLAN TERMINATIONS AND TRUSTEESHIPS

	1986 actual	1987 actual	1988 estimate	1989 estimate
Plans terminated during year:				
With sufficient assets	2	10,865	9,000	9,000
With insufficient assets	100	61	104	104
Government trusteeships at end of year	1,241	1,264	1,369	1,474
Payees in Government trusteeships receiving monthly benefits from the Corporation	94,000	113,477	123,477	133,477
Checks issued	620,063	NA	NA	NA

NA–Not available.

Source: Fiscal year 1989 Budget of the United States, appendix.

PART 5

BUDGET TABLES, DESCRIPTION OF FISCAL YEAR 1989 ADMINISTRATION BUDGET PROPOSALS, AND DESCRIPTION OF THE BALANCED BUDGET AND EMERGENCY DEFICIT CONTROL ACT OF 1985

Section 1. Budget Tables

TABLE 1.—OUTLAYS FOR MAJOR SPENDING CATEGORIES FOR SELECTED YEARS AS A PERCENT OF BUDGET AND GNP, AND IN NOMINAL DOLLARS

[By fiscal year]

	1965	1970	1975	1980	1985	1988	1989 [1]	1993 [1]
				As a percent of budget				
National defense	42.8	41.8	26.0	22.7	26.7	27.2	26.1	24.7
Social Security	14.5	15.0	19.0	19.8	19.7	20.6	20.5	21.5
Medicare		3.5	4.2	5.7	7.4	8.2	8.5	10.5
Other entitlements, and mandatories	15.4	15.8	24.1	22.0	19.4	18.3	18.2	17.6
Nondefense discretionary spending	26.9	22.6	25.2	26.1	18.2	16.6	17.1	15.8
Net interest	7.3	7.4	7.0	8.9	13.7	14.3	14.7	14.8
Offsetting receipts	−6.8	−5.9	−5.6	−5.1	−5.1	−5.2	−5.1	−4.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
				As a percent of GNP				
National defense	7.5	8.2	5.7	5.0	6.4	6.1	5.9	5.3
Social Security	2.5	3.0	4.1	4.4	4.7	4.6	4.7	4.6
Medicare		.7	.9	1.3	1.8	1.9	1.9	2.3
Other entitlements and mandatories	2.6	3.0	5.2	4.7	4.6	4.1	4.1	3.8
Nondefense discretionary spending	4.8	4.6	5.6	5.9	4.5	3.7	3.9	3.4
Net interest	1.3	1.5	1.5	2.0	3.3	3.2	3.3	3.2
Offsetting receipts	−1.2	−1.2	−1.2	−1.1	−1.3	−1.2	−1.2	−1.1
Total	17.6	19.8	21.8	22.1	24.0	22.5	22.7	21.5
				In nominal dollars (billions)				
National defense	50.6	81.7	86.5	134.0	252.7	287	295	345
Social Security	17.1	29.4	63.1	117.1	186.5	217	232	300
Medicare		6.8	14.1	33.9	69.8	87	96	147
Other entitlements and mandatories	17.4	30.0	78.6	127.2	181.5	193	206	246
Nondefense discretionary spending	32.5	45.1	83.3	156.6	175.8	175	193	221
Net interest	8.6	14.4	23.2	52.5	129.4	155	166	206
Offsetting receipts	−8.0	−11.6	−18.5	−30.3	−49.5	−55	−58	−69
Total	118.2	195.6	332.3	590.9	946.3	1,055	1,129	1,396

[1] CBO baseline projections.

Source: CBO, "The Economic and Budget Outlook: Fiscal Years 1989–1993."

TABLE 2.—FEDERAL REVENUES BY SOURCE AS A PERCENTAGE OF TOTAL REVENUES AND AS A PERCENTAGE OF GNP FOR FISCAL YEARS 1965, 1970, 1975, 1980, 1985, 1988, 1989, AND 1993

Revenue source by type of tax	Fiscal year—							
	1965	1970	1975	1980	1985	1988	1989	1993
Percent of revenues:								
Individual income	41.8	46.9	43.9	47.2	45.6	43.5	43.6	45.5
Corporate income	21.8	17.0	14.5	12.5	8.4	11.0	11.2	10.6
Social insurance	19.0	23.0	30.3	30.5	36.1	36.8	36.9	36.8
Excise	12.5	8.1	5.9	4.7	4.9	3.8	3.6	2.6
Estate and gift	2.3	1.9	1.6	1.2	.9	.9	.8	.7
Other	2.6	3.0	3.7	3.8	4.2	4.0	4.0	3.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Percent of GNP:								
Individual income	7.2	9.1	8.0	9.1	8.5	8.3	8.3	8.8
Corporate income	3.8	3.3	2.7	2.4	1.6	2.1	2.1	2.1
Social insurance	3.3	4.5	5.5	5.9	6.7	7.1	7.1	7.1
Excise	2.2	1.6	1.1	.9	.9	.7	.7	.5
Estate and gift	.4	.4	.3	.2	.2	.2	.2	.1
Other	.4	.5	.6	.8	.8	.5	.7	.8
Total	17.3	19.5	18.3	19.4	18.6	19.1	19.1	19.4
In nominal dollars (billions):								
Individual income	48.8	90.4	122.4	244.1	334.5	390	415	574
Corporate income	25.5	32.8	40.6	64.6	61.3	99	107	134
Social insurance	22.2	44.4	84.5	157.8	265.2	330	352	464
Excise	14.6	15.7	16.6	24.3	36.0	34	34	33
Estate and gift	2.7	3.6	4.6	6.4	6.4	8	8	9
Other	3.0	5.8	10.4	19.9	30.6	36	38	47
Total revenues	116.8	192.8	279.1	517.1	734.1	897	953	1,262

Note.—Columns may not add due to rounding.

Source: Congressional Budget Office, "The Economic and Budget Outlook: Fiscal Years 1989–1993."

TABLE 3.—CBO BASELINE REVENUE PROJECTIONS BY SOURCE

[By fiscal year, in billions of dollars]

Major source	1987 actual	1988 base	Projections				
			1989	1990	1991	1992	1993
Individual income	393	390	415	454	494	533	574
Corporate income	84	99	107	119	126	130	134
Social insurance	303	330	352	380	407	433	464
Excise	33	34	34	35	33	33	33
Estate and gift	7	8	8	8	8	8	9
Customs duties	15	16	17	18	20	21	23
Miscellaneous	19	20	21	22	23	24	24
Total revenues	854	897	953	1,036	1,112	1,181	1,262

Source: Congressional Budget Office, "The Economic and Budget Outlook: Fiscal Years 1989–1993."

TABLE 4.—CBO BASELINE PROJECTIONS FOR PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS FOR FISCAL YEARS 1987–93

[Outlays, in billions of dollars]

	1987 actual	1988	1989	1990	1991	1992	1993
Social Security (OASDI)	208.1	220.0	235.0	252.3	269.4	286.5	303.9
OASI	186.8	198.0	211.8	227.7	243.2	258.7	274.4
DI	21.3	22.0	23.3	24.7	26.2	27.8	29.5
Medicare	81.6	88.9	97.4	109.3	121.3	134.7	149.1
HI	50.8	53.7	57.5	64.1	70.1	76.8	83.7
SMI	30.8	35.2	39.9	45.2	51.2	57.9	65.4
Trade adjustment assistance	.1	.1	.1	.1	.1	.1	.1
Unemployment assistance	17.9	18.1	19.1	19.9	20.5	21.2	22.0
AFDC and child support	10.5	10.9	11.4	11.8	12.0	12.2	13.3
Earned income tax credit [1]	1.4	3.0	4.1	4.3	4.6	4.8	5.0
SSI [2]	10.9	12.7	12.7	12.6	14.6	15.7	17.0
Social services (Title XX)	2.7	2.7	2.7	2.7	2.7	2.7	2.7
Child welfare, foster care, adoption assistance	.8	1.3	1.3	1.3	1.4	1.5	1.5
SMI premiums	6.5	8.9	10.3	11.0	11.8	12.5	13.2
Total	340.5	366.6	394.1	425.3	458.4	491.9	527.8

[1] Refunded portion of credit only.

[2] SSI payments include 13 months of benefit payments in 1988 and 11 months of benefit payments in 1990.

Source: Congressional Budget Office.

TABLE 5.—WAYS AND MEANS PROGRAM OUTLAYS COMPARED WITH TOTAL FEDERAL GOVERNMENT OUTLAYS FOR SELECTED YEARS

[In billions of dollars]

	1970	1975	1980	1985	1989 [1]	1993 [1]
Social Security (including medicare)	37.5	79.5	153.5	262.4	332.4	453.0
Unemployment compensation and trade adjustment assistance	3.3	13.3	16.1	17.7	19.2	22.1
Public assistance and social services (AFDC, SSI, title XX, EITC, and child welfare programs)	5.1	13.5	17.8	23.3	32.2	39.5
Other entitlement programs	21.9	51.5	92.0	136.8	149.2	178.4
Nondefense discretionary spending	43.6	75.6	141.2	172.1	193.0	221.0
National defense	81.7	86.5	134.0	252.7	295.0	345.0
Net interest	14.4	23.2	52.5	129.4	166.0	206.0
Offsetting receipts	−11.7	−18.4	−30.4	−48.1	−58.0	−69.0
Total	195.7	324.2	576.7	946.3	1,129.0	1,396.0

[1] Based upon CBO baseline current law projections.

Source: Congressional Budget Office, "The Economic and Budget Outlook: Fiscal Years 1989–1993."

TABLE 6.—WAYS AND MEANS PROGRAM OUTLAYS COMPARED WITH TOTAL FEDERAL PROGRAM OUTLAYS IN PERCENTAGE TERMS FOR SELECTED YEARS

	1970	1975	1980	1985	1989[1]	1993[1]
Social Security (including medicare)	19.2	24.5	26.6	27.7	29.4	32.4
Unemployment compensation and trade adjustment assistance	1.7	4.1	2.8	1.9	1.7	1.6
Public assistance and social services (AFDC, SSI, title XX, EITC, low income energy assistance and child welfare programs)	2.6	4.2	3.1	2.5	2.9	2.8
Other entitlement programs	11.1	15.8	15.9	14.5	13.2	12.8
Nondefense discretionary spending	22.3	23.3	24.5	18.2	17.1	15.8
National defense	41.7	26.7	23.2	26.7	26.1	24.7
Net interest	7.4	7.2	9.1	13.7	14.7	14.8
Offsetting receipts	−6.0	−5.7	−5.3	−5.1	−5.1	−4.9
Total	100.0	100.0	100.0	100.0	100.0	100.0
Ways and Means programs as percent of total Federal Government outlays, less interest	25.3	35.3	35.7	37.8	39.9	43.2

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[1] Based on CBO baseline current law projections.

TABLE 7.—HISTORICAL OUTLAYS FOR ENTITLEMENTS AND OTHER MANDATORY SPENDING

[By fiscal years, in billions of dollars]

	1975	1980	1981	1982	1983	1984	1985	1986	1987
Means-tested programs:									
Medicaid	6.8	14.0	16.8	17.4	19.0	20.1	22.7	25.0	27.4
Food stamps [1]	4.6	9.1	11.3	11.0	12.7	12.4	12.5	12.4	12.4
Supplemental security income	4.8	6.4	7.2	7.7	8.7	8.5	9.6	10.3	10.9
AFDC and child support enforcement	5.1	7.3	8.2	8.0	8.4	8.9	9.2	9.9	10.5
Veteran's pensions	2.7	3.6	3.8	3.9	3.9	3.9	3.8	3.9	3.8
Child nutrition	1.5	3.4	3.4	3.0	3.3	3.5	3.7	3.8	4.0
Guaranteed student loans	.1	1.4	2.3	3.0	2.6	3.2	3.5	3.3	2.6
Other	.2	1.4	1.7	1.5	1.5	1.7	1.9	2.3	2.3
Total, means-tested programs	25.8	46.6	54.7	55.5	60.1	62.2	66.9	70.9	73.9
Non-means-tested programs:									
Social Security	63.1	117.1	138.0	154.1	168.6	176.1	186.5	196.7	205.2
Medicare	14.1	33.9	41.3	49.2	55.5	70.0	69.9	74.2	79.9
Subtotal	77.2	151.0	179.2	203.2	224.1	237.1	256.3	270.9	285.2
Other retirement and disability:									
Federal civilian [2]	7.1	14.9	17.8	19.7	20.9	21.9	23.1	24.1	26.0
Military	6.2	11.9	13.7	14.9	15.9	16.5	15.8	17.6	18.1
Other	3.1	4.7	5.1	5.2	5.1	4.9	5.1	4.9	5.1
Subtotal	16.4	31.5	36.6	39.8	41.9	43.3	44.0	46.7	49.2
Unemployment compensation	12.8	16.9	18.3	22.2	29.7	16.8	15.8	16.1	17.1
Other programs:									
Veteran's benefits [3]	10.2	11.0	12.2	12.5	12.8	12.8	12.9	12.9	13.1
Farm price supports [3]	.7	2.8	4.1	11.8	19.1	7.8	18.1	26.2	22.7
General revenue sharing	6.1	6.8	5.1	4.6	4.6	4.6	4.6	5.1	.0
Social services	2.9	3.7	3.9	3.4	3.4	4.4	3.5	4.0	4.1
Other	3.7	7.9	6.9	4.4	3.2	5.9	15.7	2.5	9.0
Subtotal	23.6	32.2	32.2	36.7	43.1	35.5	54.8	50.7	48.9
Total, non-means-tested programs	130.0	231.6	266.3	302.0	338.9	332.6	370.9	384.5	400.2
Total outlays	155.8	278.2	321.0	357.5	399.0	394.8	437.8	455.4	474.1

[1] Includes nutrition assistance for Puerto Rico.

[2] Includes Coast Guard retirement.

[3] Includes veterans' compensation, readjustment benefits, life insurance, and housing projects.

Source: Congressional Budget Office.

TABLE 8.—COMPARISION OF AVERAGE ANNUAL GROWTH RATES FOR MAJOR ENTITLEMENT AND MANDATORY SPENDING PROGRAMS FOR SELECTED TIME PERIODS, BASED ON VARIOUS ADJUSTMENTS FOR INFLATION AND POPULATION GROWTH

Between years adjusted for	1975–87 [1]	1975–87 [2]	1975–87 [2] [3]	1975–81 [2] [3]	1981–86 [2] [3]	1981–86 [2] [4]
Means-tested programs:						
Medicaid	12.3	5.5	4.4	5.5	2.9	3.9
Food stamps [5]	8.6	2.0	1.0	5.4	−3.2	−2.6
Supplemental security income	7.1	.6	−.5	−2.9	2.1	4.2
AFDC and child support enforcement	6.2	−.3	−1.3	−1.8	−1.3	−2.4
Veteran's pensions	2.9	−3.4	−4.3	−3.9	−4.5	−2.5
Child nutrition	8.5	1.9	.9	4.0	−2.8	−2.0
Guaranteed student loans	31.2	23.2	22.0	53.0	2.1	4.9
Other	22.6	15.1	14.0	29.6	.9	.9
Total, means-tested programs	9.2	2.5	1.5	2.9	.1	.7
Non-means-tested programs:						
Social Security	10.3	3.6	2.6	3.4	2.0	.8
Medicare	15.6	8.5	7.4	8.5	6.8	5.6
Subtotal	11.5	4.7	3.7	4.4	3.2	2.0
Other retirement and disability:						
Federal civilian [6]	11.4	4.6	3.6	5.8	1.0	−.2
Military	9.3	2.7	1.6	3.6	−.1	−1.2
Other	4.2	−2.1	−3.1	−1.4	−5.7	−6.8
Subtotal	9.6	2.9	1.9	3.7	−.2	−1.4
Unemployment compensation	2.4	−3.8	−4.8	−3.7	−7.4	−6.4
Other programs:						
Veterans' benefits [7]	2.1	−4.1	−5.1	−6.5	−3.9	−5.0
Farm price supports	33.6	25.5	24.2	21.8	37.7	37.7
General revenue sharing	−100.0	−100.0	−100.0	−11.9	−5.0	−5.0
Social services	2.9	−3.3	−4.3	−4.7	−4.5	−4.5
Other	7.7	1.1	.1	.7	−22.4	−22.4
Subtotal	6.3	−.2	−1.2	−4.4	4.1	4.1
Total, non-means-tested programs	9.8	3.1	2.1	2.3	2.3	2.3
Total outlays	9.7	3.0	2.0	2.4	1.9	1.9

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[1] Nominal growth.

[2] Adjusted for inflation (based on the CPI–U).

[3] Adjusted for overall population growth.

[4] Adjusted for population growth specific to each program category (e.g., Medicaid outlays adjusted for growth in the number of pre-transfer (means-tested) poor among the elderly and among families with children, Social Security and Medicare outlays adjusted for growth in the overall elderly population and AFDC outlays adjusted for growth in the number of pre-transfer (means-tested) poor among single parents with children).

[5] Includes nutrition assistance for Puerto Rico.

[6] Includes Coast Guard retirement.

[7] Includes veterans' compensation, readjustment benefits, life insurance, and housing projects.

TABLE 9.—CBO BASELINE OUTLAY PROJECTIONS FOR ENTITLEMENTS AND OTHER MANDATORY SPENDING CATEGORIES

[By fiscal year, in billions of dollars]

Category	1987 actual	1988 base	Projections				
			1989	1990	1991	1992	1993
Means-tested programs:							
Medicaid	27	31	34	38	42	47	52
Food stamps	12	12	13	13	14	14	16
Supplemental security income [1]	11	13	13	13	15	16	17
Family support	11	11	11	12	12	12	13
Veterans' pensions	4	4	4	4	4	3	3
Child nutrition	4	4	5	5	5	6	6
Earned income tax credit	1	3	4	4	5	5	5
Guaranteed student loans	3	3	3	3	3	3	3
Other	1	2	2	2	2	2	2
Total, means-tested programs	74	82	89	94	101	108	117
Non-means-tested programs:							
Social Security	205	217	232	249	266	283	300
Medicare	80	87	96	107	119	133	147
Subtotal	285	304	327	356	385	416	447
Other retirement and disability:							
Federal civilian [2]	26	27	29	32	33	36	38
Military	18	19	20	22	23	24	26
Other	5	5	5	5	5	5	5
Subtotal	49	51	54	58	61	65	69
Unemployment compensation	17	15	16	17	17	18	19
Other programs:							
Veterans' benefits [3]	13	14	14	14	15	15	16
Farm price supports	23	18	18	18	17	14	13
Social services	4	4	5	5	5	5	5
Other	9	8	10	9	9	8	8
Subtotal	49	45	47	47	45	42	41
Total, non-means-tested programs	400	415	444	478	509	541	576
Total all entitlements and other mandatory spending	474	497	533	572	610	649	693

[1] In 1988, SSI has 13 payments and in 1990 11 payments.

[2] Includes Coast Guard retirement.

[3] Includes veterans' compensation, readjustment benefits, life insurance, and housing programs.

Source: Congressional Budget Office, "The Economic and Budget Outlook: Fiscal Years 1989–1993."

TABLE 10.—SPENDING FOR FEDERAL PROGRAMS BENEFITING ELDERLY PEOPLE AND FAMILIES WITH CHILDREN

[In billions of dollars, fiscal year 1985] [1]

Program	Total	For elderly [2]	For families with children under age 18 [3]
Cash transfers:			
Social Security	184.1	[4,5] 140.0	[5] 19.6
Railroad retirement	6.2	4.9	.2
Supplemental security income	8.5	[6] 3.9	1.1
AFDC	8.5	—	[7] 8.5
Earned income tax credit	[8] 1.1	[9,10] .0	[10] 1.0
Unemployment compensation	16.0	.3	7.3
In-kind transfers:			
Food stamps [11]	11.6	[12] 1.0	[12] 9.4
Child nutrition [13]	5.3	—	[7,13] 5.3
Elderly feeding program	.1	[7] .1	—
Medicare	[14] 64.1	[12] 57.5	[12] 4.7
Medicaid	21.4	[12,15] 8.0	[12,15,16] 10.1
Housing assistance [17]	11.2	[18] 4.5	[18] 5.5
Low income home energy assistance program	2.1	[12] .6	[12] 1.0
Federal retirement and disability:			
Civilian	23.0	15.2	.8
Military	15.8	4.5	2.8
Veteran's benefits [19]	14.1	4.3	3.0
Education:			
Compensatory education	3.7	—	[20] 3.7
Impact aid	.7	—	[20] .7
Education for the handicapped	1.3	—	[20] 1.3
Other programs	1.7	—	[20] 1.7
Services and other aid			
Child support enforcement	.6	—	[7] .6
Human development [21]	1.9	[22] .7	[22] 1.1
Family social services	.7	—	[7] .7
Work incentive program	.3	—	[7] .3
Total	404.0	[23] 245.5	[23] 90.4
Other programs for which spending could not be allocated to subgroups:			
Coal miners [24]	1.6	(*)	(*)
Veteran's health care	[25] 8.5	(*)	(*)
Social services block grant	2.7	(*)	(*)
Community services block grant	.4	(*)	(*)
Training and employment [26]	3.4	(*)	(*)
Community service for older Americans	.3	(*)	(*)
Total	16.9	(*)	(*)

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[1] Where available, spending values are outlays for benefits provided to recipients. When outlays were not available, obligations were used.

[2] Except where otherwise noted, elderly units are people age 65 or older, their spouses regardless of age, and any children under age 18 living with them. Benefits for elderly units with children will also be counted as benefits "For Families with Children Under Age 18."

[3] Except where otherwise noted, familes with children under age 18 are parents of children under age 18 and those children. Benefits for these units will also be counted as benefits "For Elderly" if one member is age 65 or over.

[4] Social Security spending for the elderly omits benefits for dependents under age 65, because program data do not separate dependents' benefits by age or primary beneficiary. Such benefits might have been as much as $10 billion in fiscal year 1985.

[5] Share derived from program data as of the end of calendar year 1983.

[6] Share derived from program data as of December 1984.

[7] Share assumed to be 100 percent due to eligibility criteria.

[8] Only the refundable portion of the earned income tax credit is considered. The tax expenditure portion, like all other tax expenditures, is omitted from the analysis.

[9] Less than $50 million.

[10] Share based on Congressional Budget Office simulations of earned income tax credit for calendar year 1984.

[11] Includes nutrition assistance for Puerto Rico. In fiscal year 1985, spending for this program was $0.8 billion.

[12] Recipient units for this item are defined as all related people living together, the Bureau of Census definition of families. These units may thus be larger than the nuclear families used generally in this analysis.

[13] Child nutrition includes school breakfast and lunches, special meal assistance, summer and child care feeding, special milk, the supplemental feeding program for women, infants, and children (WIC), and the commodity supplemental food program. Some benefits go to women who are pregnant with their first child.

[14] Excludes value of Supplemental Medical Insurance premiums; these totaled about $5.5 billion in fiscal year 1984.

[15] Share derived from program data for 1980 and from Current Population Survey data for calendar year 1984.

[16] Spending may be understated, due to lack of data for institutionalized recipients.

[17] Housing assistance includes Section 8, public and Indian housing, rent supplements, and Sections 235 and 236. Recipient units are all people sharing households. Units are elderly if at least one member is age 62 or over; units are considered families with children if at least one member is under age 18.

[18] Share estimated based on unpublished program data for fiscal year 1981.

[19] Veteran's benefits include veterans' pensions and compensation.

[20] Some benefits may go to families with children age 18 and over (and are students) and no children under age 18.

[21] Human Development includes Head Start, child abuse and family violence spending, programs for runaway and homeless youth, and Title III services and meals for the elderly.

[22] Share based on budgeted amounts for specific subprogram in fiscal year 1985.

[23] Totals for the elderly and for families with children include only those amounts for program spending that could be allocated by recipient type. Totals thus understate the amounts spent on two groups.

[24] Includes Special Benefits for Disabled Coal Miners and Black Lung Disability Benefits.

[25] Roughly one-third of beneficiaries are age 65 or older; costs for their care are higher than for nonelderly beneficiaries, but actual amounts are difficult to determine.

[26] Includes summer youth employment and training, dislocated worker assistance, Job Corps, veterans' employment, trade adjustment assistance, block grants to states, and programs for Native Americans and migrant and seasonal workers.

— No spending for this group, as a result of program rules.

(*) Unable to estimate share going to subgroups.

Note.—Except as noted, the shares of total outlays are based on Current Population Survey data for calendar year 1984.

Source: Budget of the United States Government, FY 1987; March 1985 Current Population Survey; Social Security Bulletin: Annual Statistical Supplement, 1984–85; Background Material and Data on Programs Within the Jurisdiction of the Committee on the Ways and Means, Committee Print WMCP: 99–2, February 22, 1985.

TABLE 11.—BUDGET OUTLAYS, RECEIPTS, AND DEFICITS

[Dollar amounts in billions]

Fiscal year	Receipts		Outlays [1]		Deficit	
	Amount	Percent of GNP	Amount	Percent of GNP	Amount	Percent of GNP
Historical Data						
1971	187.1	17.7	210.2	19.9	−23.0	2.2
1972	207.3	18.0	230.7	20.0	−23.4	2.0
1973	230.8	18.0	245.7	19.1	−14.9	1.2
1974	263.2	18.6	269.4	19.0	−6.1	.4
1975	279.1	18.3	332.3	21.8	−53.2	3.5
1976	298.1	17.5	371.8	21.9	−73.7	4.3
1977	355.6	18.4	409.2	21.1	−53.6	2.8
1978	399.6	18.4	458.7	21.1	−59.2	2.7
1979	463.3	18.9	503.5	20.5	−40.2	1.6
1980	517.1	19.4	590.9	22.2	−73.8	2.8
1981	599.3	20.1	678.2	27.7	−78.9	2.6
1982	617.8	19.7	745.7	23.7	−127.9	4.1
1983	600.6	18.1	808.3	24.3	−207.8	6.3
1984	666.5	18.0	851.8	23.1	−185.3	5.0
1985	734.1	18.6	946.3	24.0	−212.3	5.4
1986	769.0	18.5	990.0	23.8	−221.0	5.3
1987	854.1	19.4	1,004.6	22.8	−150.4	3.4
Congressional Budget Office Baseline						
1988	897	19.2	1,055	22.5	−157	3.4
1989	953	19.1	1,129	22.7	−176	3.5
1990	1,036	19.4	1,203	22.6	−167	3.1
1991	1,112	19.5	1,269	22.3	−158	2.8
1992	1,181	19.4	1,332	21.9	−151	2.5
1993	1,262	19.4	1,396	21.5	−134	2.1
OMB Current Service Totals						
1988	908.9	19.3	1,056.4	22.4	−147.5	3.1
1989	964.0	19.2	1,102.4	21.9	−138.5	2.8
1990	1,043.2	19.4	1,154.2	21.4	−111.0	2.1
1991	1,123.2	19.5	1,209.2	21.0	−86.0	1.5
1992	1,189.0	19.4	1,251.9	20.5	−62.9	1.0
1993	1,257.3	19.4	1,296.2	20.1	−39.0	.6

[1] Includes outlays (and deficits) that are off-budget under prior and current law.

[2] Less than 0.05 percent.

Source: Congressional Budget Office, "The Economic and Budget Outlook: Fiscal Years 1989–1993" and Budget of the U.S. Government, Fiscal Year 1989.

TABLE 12.—REVENUE, OUTLAYS, AND SURPLUS OR DEFICITS FOR THE TOTAL BUDGET, AND OASDHI TRUST FUNDS AS A PERCENT OF GROSS NATIONAL PRODUCT

		Total budget		OASDHI			Remainder of the budget		
	Revenues	Outlays	Deficit (−) or surplus	Revenues [1]	Outlays [2]	Deficit (−) or surplus	Revenues	Outlays	Deficit (−) or surplus
1960	18.3	18.2	0.1	2.3	2.3	−0.0	16.0	15.9	0.1
1961	18.2	18.9	−.6	2.5	2.4	.1	15.7	16.5	−.7
1962	17.9	19.2	−1.3	2.3	2.6	−.2	15.5	16.6	−1.1
1963	18.1	18.9	−.8	2.6	2.7	−.1	15.6	16.3	−.7
1964	17.9	18.8	−.9	2.7	2.6	.1	15.2	16.2	−1.0
1965	17.4	17.6	−.2	2.6	2.6	.0	14.7	15.0	−.2
1966	17.7	18.2	−.5	2.8	2.8	.0	14.9	15.4	−.5
1967	18.7	19.8	−1.1	3.6	3.1	.6	15.1	16.8	−1.7
1968	18.0	21.0	−3.0	3.6	3.3	.3	14.4	17.7	−3.3
1969	20.1	19.8	.3	3.9	3.4	.5	16.2	16.3	−.1
1970	19.5	19.8	−.3	4.2	3.6	.7	15.3	16.2	−.9
1971	17.7	19.9	−2.2	4.3	3.9	.3	13.5	16.0	−2.5
1972	18.0	20.0	−2.0	4.3	4.0	.2	13.7	16.0	−2.3
1973	18.0	19.2	−1.2	4.5	4.4	.2	13.5	14.8	−1.3
1974	18.6	19.0	−.4	4.9	4.5	.4	13.7	14.5	−.8
1975	18.3	21.8	−3.5	5.2	4.9	.3	13.1	16.9	−3.8
1976	17.6	21.9	−4.3	5.0	5.1	.1	12.6	16.8	−4.2
1977	18.4	21.2	−.8	5.0	5.2	.2	13.4	16.0	−.6
1978	18.4	21.1	−2.7	5.0	5.1	.2	13.4	16.0	−2.6
1979	18.9	20.6	−1.6	5.1	5.1	.0	13.9	15.5	−1.6
1980	19.4	22.1	−2.8	5.3	5.3	.0	14.0	16.8	−2.8
1981	20.1	22.7	−2.6	5.6	5.7	.0	14.5	17.1	−2.6
1982	19.7	23.8	−4.1	5.9	6.1	.2	13.8	17.7	−3.9
1983	18.1	24.3	−6.3	6.5	6.3	.2	11.6	18.0	−6.4
1984	18.1	23.1	−5.0	6.2	6.1	.1	11.9	17.0	−5.1
1985	18.6	24.0	−5.4	6.4	6.1	.3	12.2	17.9	−5.7
1986	18.3	23.6	−5.3	6.5	6.0	.6	11.8	17.7	−5.8
1987	19.4	22.8	−3.4	6.6	5.9	.7	12.8	16.9	−4.1
1988 [3]	19.3	22.4	−3.1	6.9	5.8	1.1	12.4	16.6	−4.2
1989 [3]	19.2	21.8	−2.6	7.0	5.8	1.3	12.2	16.0	−3.9
1990 [3]	19.4	21.3	−1.9	7.2	5.8	1.5	12.2	15.6	−3.4
1991 [3]	19.5	20.9	−1.4	7.3	5.7	1.6	12.2	15.2	−2.9
1992 [3]	19.4	20.3	−.8	7.4	5.7	1.6	12.1	14.6	−2.5
1993 [3]	19.5	19.8	−.4	7.5	5.7	1.8	12.0	14.1	−2.1
1960–69 [4]	18.2	19.0	.8	2.9	2.8	.1	15.3	16.3	−.9
1970–79 [4]	18.3	20.4	1.9	4.7	4.6	.2	13.6	15.9	−2.1
1980–89 [4]	19.0	23.1	−4.1	6.3	5.9	.4	12.7	17.2	−4.5
1990–93 [4]	19.5	20.6	−1.1	7.3	5.7	1.6	12.1	14.8	−2.7

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[1] OASDHI revenues include all revenues to those funds, including interest.

[2] OASDHI outlays equal the totals of OASI plus DI plus HI.

[3] Projected under Administration policies.

[4] Average for these years.

Source: Office of Management and Budget, Historical Tables, Budget of the United States Government, Fiscal Year 1988; Tables 1.2, 2.4, 13.1.

TABLE 13.—FEDERAL FINANCES AND THE FEDERAL DEBT, 1955–91

[Dollar amounts in billions]

	Total deficit		Federal debt, end of year					
			Gross		Held by Government accounts		Held by the public	
	Amount	Percent of GNP	Amount	Percent of GNP	Amount	Percent of GNP	Amount	Percent of GNP
1955	−3.0	−.8	274.4	71.0	47.8	12.4	226.6	58.6
1956	3.9	.9	272.8	65.2	50.5	12.1	222.2	53.2
1957	3.4	.8	272.4	61.8	52.9	12.0	219.4	49.8
1958	−2.8	−.6	279.7	62.1	53.3	11.8	226.4	50.3
1959	−12.8	−2.7	287.8	59.8	52.8	11.0	235.0	48.8
1960	.3	.1	290.9	57.4	53.7	10.6	237.2	46.8
1961	−3.3	−.6	292.9	56.5	54.3	10.5	238.6	46.0
1962	−7.1	−1.3	303.3	54.4	54.9	9.8	248.4	44.5
1963	−4.8	−.8	310.8	52.9	56.3	9.6	254.5	43.3
1964	−5.9	−.9	316.8	50.3	59.2	9.4	257.6	40.9
1965	−1.4	−.2	323.2	48.0	61.5	9.1	261.6	38.9
1966	−3.7	−.5	329.5	44.6	64.8	8.8	264.7	35.8
1967	−8.6	−1.1	341.3	43.0	73.8	9.3	267.5	33.7
1968	−25.2	−3.0	369.8	43.5	79.1	9.3	290.6	34.2
1969	3.2	.3	367.1	39.5	87.7	9.4	279.5	30.1
1970	−2.8	.3	382.6	38.6	97.7	9.9	284.9	28.8
1971	−23.0	2.2	409.5	38.8	105.1	10.0	304.3	28.8
1972	−23.4	2.0	437.3	37.9	113.6	9.8	323.8	28.1
1973	−14.9	1.2	468.4	36.6	125.4	9.8	343.0	26.8
1974	−6.1	.4	486.2	34.3	140.2	9.9	346.1	24.4
1975	−53.2	3.5	544.1	35.7	147.2	9.7	396.9	26.1
1976	−73.7	4.3	631.9	37.2	151.6	8.9	480.3	28.3
1977	−53.6	2.8	709.1	36.7	157.3	8.1	551.8	28.5
1978	−59.2	2.7	780.4	35.9	169.5	7.8	610.9	28.1
1979	−40.2	1.6	833.8	34.1	189.2	7.7	644.6	26.3
1980	−73.8	2.8	914.3	34.2	199.2	7.5	715.1	26.8
1981	−78.9	2.6	1,003.9	33.6	209.5	7.0	794.4	26.6
1982	−127.9	4.1	1,147.0	36.5	217.6	6.9	929.4	29.6
1983	−207.8	6.3	1,381.9	41.6	240.1	7.2	1,141.8	34.4
1984	−185.3	5.0	1,576.7	42.8	264.2	7.2	1,312.6	35.6
1985	−212.3	5.4	1,827.5	46.3	317.6	8.1	1,509.9	38.3
1986	−221.2	5.3	2,130.0	50.8	383.9	9.2	1,746.1	41.6
1987	−150.4	3.4	2,355.3	53.4	457.4	10.4	1,897.8	43.0
1988 estimate	−146.7	3.1	2,581.6	54.9	556.5	11.8	2,025.1	43.0
1989 estimate	−129.5	2.6	2,825.3	56.2	673.2	13.4	2,152.1	42.8
1990 estimate	−104.2	1.9	3,053.0	56.7	797.3	14.8	2,255.7	41.9
1991 estimate	−79.3	1.4	3,269.2	56.8	934.7	16.2	2,334.4	40.5

Note.—Excludes transition quarter. Estimates assume Administration's budget.

TABLE 14.—NET SAVINGS AND INVESTMENT FLOWS AS A PERCENTAGE OF GNP

[NIPA basis]

	(1) Net private domestic savings	(2) State and local surplus	(3) Federal deficit	(4) Net domestic savings available for domestic investment (1) + (2) − (3)	(5) Net private domestic investment	(6) Net domestic savings shortfalls (5) − (4) = net capital inflows
1950–59	7.5	−0.2	−0.1	7.8	7.5	−0.3
1960–69	8.1	.0	.3	7.8	7.1	−.7
1970–79	8.1	.8	1.7	7.2	6.9	−.3
1980	6.4	1.0	2.2	5.2	4.9	−.3
1981	6.6	1.1	2.1	5.6	5.5	−.1
1982	5.5	1.1	4.6	2.0	2.0	.0
1983	5.7	1.4	5.2	1.9	3.1	1.2
1984	6.8	1.7	4.5	4.0	6.6	2.6
1985	5.7	1.6	4.9	2.4	5.1	2.7
1986	5.3	1.3	4.8	1.8	5.1	3.3
1987	4.3	1.0	3.4	1.9	5.3	3.4

Sources: Congressional Budget Office; Department of Commerce, Bureau of Economic Analysis.

TABLE 15.—EFFECTS ON CBO BASELINE BUDGET PROJECTIONS OF SELECTED CHANGES IN ECONOMIC ASSUMPTIONS

[By fiscal year, in billions of dollars]

Economic variables	1988	1989	1990	1991	1992	1993
Real growth: Effect of 1-percentage-point higher annual rate beginning January 1988:						
Change in revenues	−5	−18	−34	−52	−71	−91
Change in budget outlays	1	3	7	13	19	28
Change in total deficit	6	21	41	64	90	119
Unemployment: Effect of 1-percentage-point lower annual rate beginning January 1988:						
Change in revenues	−21	−35	−38	−40	−42	−43
Change in budget outlays	4	7	11	15	19	24
Change in total deficit	24	42	48	55	61	67
Interest rates: Effect of 1-percentage-point higher annual rates beginning January 1988:						
Change in revenues	0	0	0	0	0	0
Changes in budget outlays	3	11	16	21	26	30
Change in total deficit	3	11	16	21	26	30
Inflation: Effect of 1-percentage-point higher annual rate beginning January 1988:						
Change in revenues	4	16	27	41	55	72
Change in budget outlays	3	14	26	39	52	66
Change in total deficit	−1	−1	−1	−2	−3	−7

[1] Less than $500 million.

Note.—Totals include Social Security which is off-budget.

Source: Congressional Budget Office, "The Economic and Budget Outlook: Fiscal Years 1989–1993."

TABLE 16.—NET EFFECT OF MAJOR TAX LEGISLATION ENACTED IN 1981–1987 ON FISCAL YEAR RECEIPTS, 1987–1991 [1]

[By fiscal years, in billions of dollars]

	1987	1988	1989	1990	1991	1988–89
Economic Recovery Tax Act of 1981	−241.7	−260.8	−285.5	−315.7	−350.2	−546.2
Tax Equity and Fiscal Responsibility Act of 1982	56.9	57.3	55.8	57.4	61.6	113.1
Highway Revenue Act of 1982	4.7	4.9	5.1	5.1	5.1	10.0
Social Security Amendments of 1983	12.1	24.6	31.0	23.9	23.9	55.6
Interest and Dividends Tax Compliance Act of 1983	−1.7	−1.8	−2.0	−2.5	−2.8	−3.8
Railroad Retirement Revenue Act of 1983	1.2	1.2	1.1	1.1	1.1	2.3
Deficit Reduction Act of 1984	22.0	25.3	27.7	31.0	34.0	53.0
Consolidated Omnibus Budget Reconciliation Act of 1985	2.7	2.9	3.0	3.0	3.2	5.9
Federal Employees' Retirement System Act of 1986	−.1	−.2	−.2	−.3	−.4	−.4
Omnibus Budget Reconciliation Act of 1986	2.7	2.5	2.0	1.0	.2	4.5
Superfund Amendments and Reauthorization Act of 1986	.4	.8	.8	.8	.8	1.6
Continuing Resolution for 1987	1.9	2.7	2.6	2.7	2.8	5.3
Tax Reform Act of 1986	21.5	−4.5	−17.2	−13.5	−9.5	−21.8
Omnibus Budget Reconciliation Act of 1987 [2]		9.1	14.3	16.2	15.6	23.3
Continuing Resolution for 1988		2.4	3.1	3.3	3.4	5.5
Net tax reduction (−)	−117.5	−133.7	−158.4	−186.3	−211.4	−292.1
ADDENDUM						
Net effect on receipts by source:						
Individual income taxes	−158.7	−193.1	−224.8	−250.2	−278.3	−418.0
Corporation income taxes	19.7	24.2	26.8	33.1	41.0	51.0
Social insurance taxes and contributions	14.1	29.2	36.0	27.9	25.8	65.3
Excise taxes	14.1	13.1	11.7	11.8	9.4	24.8
Estate and gift taxes	−7.6	−7.8	−8.7	−9.3	−9.7	−16.5
Customs duties	.7	.2	.2	(3)	(3)	.3
Miscellaneous receipts	.2	.5	.4	.4	.3	.9

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[1] These estimates are based on the direct effect only of legislative changes at a given level of economic activity. Induced effects on the economy are taken into account in forecasting incomes, however, and in this way affect the receipts estimates by major source and in total.

[2] These estimates reflect only the effect on budget receipts. The Act reclassified the ad valorem customs user fee as an offsetting collection, rather than as a budget receipt, which reduces outlays by the following amounts: 1988, $0.1 billion; 1989, $0.1 billion, and 1990, $0.7 billion.

[3] $50 million or less.

Source: Budget of the United States Government: Fiscal Year 1989, p. 4.4.

TABLE 17.—BUDGET DEFICIT IMPACTS OF CALENDAR YEAR 1987 RECONCILIATION BILL AND CONTINUING RESOLUTION PURSUANT TO THE ECONOMIC SUMMIT AGREEMENT

[In billions]

	1988	1989
Deficit Reduction Already Achieved		
Revenues:		
Taxes	9.2	14.2
IRS compliance (gross)	1.8	2.5
User fees	−.5	−.6
Total revenues	10.5	16.1
Outlays:		
National defense	5.1	7.4
Nondefense discretionary	2.5	1.6
Entitlements and other mandatory spending		
Medicare	2.1	3.8
Farm price supports	1.2	.9
Postal service and civil service	.8	.6
Pension Benefit Guaranty Corporation premiums	.4	.4
Veterans Administration loan sales and fees	.8	.8
Guaranteed student loan balances	.2	
Other	.2	−.4
Subtotal	5.7	6.2
Other user fees (offsetting receipts)	.8	.9
Asset sales and prepayments	7.7	
Debt service	1.3	3.4
Total outlays	23.1	18.9
Deficit reduction:		
Total reduction to date	33.6	35.6
Additional Deficit Reduction to be Achieved		
Revenues—IRS compliance		.4
Outlays:		
National defense		1.2
Nondefense discretionary		1.8
Asset sales		3.5
Net interest		.3
Total		6.8
Deficit reduction		7.2
Total Deficit Reduction		
Deficit reduction	33.6	42.8

Source: Congressional Budget Office.

TABLE 18.—SUMMARY OF DEFICIT IMPACT OF THE 1987 RECONCILIATION BILL BY MAJOR PROGRAM [1]

[By fiscal year, in millions of dollars]

	1988	1989	1990	3-year total
I. Social Security (OASDI)	11	54	8	73
II. Public assistance and unemployment	26	73	69	168
III. Medicare	−2,093	−3,841	−3,888	−9,822
IV. Title XX	48	2	0	50
V. Debt collection	−270	0	0	−270
VI. PBGC premium increases	−400	−400	−410	−1,210
Total spending reduction	−2,678	−4,112	−4,221	−11,011

[1] Includes only provisions within the jurisdiction of the Committee on Ways and Means. Includes only direct spending effects.

Note.—Minus sign (−) denotes impact upon deficit.

TABLE 19.—DEFICIT IMPACT OF THE 1987 RECONCILIATION BILL BY PROVISION [1]

[By fiscal year, in millions of dollars]

	1988	1989	1990	3-year total
I. Provisions relating to Social Security (OASDI)				
Applicability of Government pension offset to certain Federal employees	0	0	0	0
Modification of agreement with Iowa to provide for certain police/firemen	−2	0	0	−2
Continuation of disability benefits during appeal	20	50	5	75
Extend disability reentitlement period from 15 to 36 months	1	5	5	11
Fees for representation of claimants in administrative proceedings [2]	−1	−2	−2	−5
Treat corporate directors as employees	−8	−1	−2	−11
Subtotal: OASDI [2]	11	54	8	73
II. Provisions relating to public assistance and unemployment compensation				
A. Aid to Families With Dependent Children:				
Fraud control under AFDC	−1	−1	−1	−3
Assistance to homeless families [3]	0	0	0	0
B. Child support enforcement services for certain families receiving Medicaid:				
Family Support Administration	3	13	13	29
Medicaid	(4)	−2	−2	−4
Food stamps	(4)	−1	−1	−2
C. Unemployment compensation				

TABLE 19.—DEFICIT IMPACT OF THE 1987 RECONCILIATION BILL BY PROVISION [1]—Continued

[By fiscal year, in millions of dollars]

	1988	1989	1990	3-year total
D. Supplemental security income:				
Extend energy aid disregard	1	1	1	3
Transfer of assets	(4)	(4)	(4)	1
Treatment of AFDC benefits	(4)	(4)	(4)	1
Temporary institutional care	(4)	2	2	4
Medicaid for window(er)s	1	6	8	15
Outreach demonstrations [2]	1	2	2	5
Personal needs allowance:				
SSI	3	12	12	27
Medicaid [5]	6	30	30	66
E. Social services, child welfare services and other provisions relating to children:				
Voluntary foster care	3	4	4	11
Foster care/child welfare	8	6	0	14
Mother/infant foster care	2	3	3	8
Increase Title XX funds	48	2	0	50
Titles XX and IVB	0	0	0	0
Commission on Children [2]	1	0	0	1
Boarder babies demonstration [2]	1	4	4	9
Study of children with AIDS [2]	(4)	(4)	0	1
Subtotal: Public assistance provisions	74	75	69	220
III. Provisions relating to Medicare				
A. Medicare part A:				
Hospital market basket update (effective April 4, 1988)	−195	−1,325	−1,515	−3,035
Indirect medical education	0	−50	−55	−105
Extend rural swing bed provisions	5	5	10	20
Extend sole community provider provisions	3	3	3	9
Hospital capital reduction (effective January 1, 1988)	−185	−265	0	−450
Access to SNFs	0	0	0	0
Pacemaker warranties	−3	−6	−6	−15
Nursing home standards reform	0	15	23	38
Sequester hospitals	−380	0	0	−380
Subtotal: Part A provision	−755	−1,623	−1,540	−3,918

TABLE 19.—DEFICIT IMPACT OF THE 1987 RECONCILIATION BILL BY PROVISION [1]—Continued

[By fiscal year, in millions of dollars]

	1988	1989	1990	3-year total
B. Medicare parts A and B:				
Prompt-pay standard (10 days in 1988, 14 in 1989)	−520	−570	−130	−1,220
Home health-conditions of part	0	([4])	5	5
Medicare secondary payer/ESRD	−2	−1	−1	−4
Subtotal: Parts A and B provisions	−522	−571	−126	−1,219
C. Medicare part B:				
MEI update (effective April 1, 1988)	−135	−600	−820	−1,555
Freeze physician services (to April 1, 1988)	−165	−0	−0	−165
Rural underserved bonus (effective January 1, 1989)	0	30	45	75
Reduce payments for overpriced procedures (effective April 1, 1988)	−95	−240	−275	−610
Limited charges for A-scans (effective April 1, 1988)	−20	−45	−50	−115
New physicians (effective April 1, 1988)	−45	−105	−130	−280
Reduce clinical lab	−65	−135	−225	−425
Fee schedules—radiologic services	0	−10	−25	−35
Payment for anesthesia services (effective April 1, 1988)	−5	−15	−15	−35
Prohibit charges for purchased services (effective April 1, 1988)	−3	−10	−10	−23
DME	−60	−60	−95	−215
Eliminate ROE for OP payments (effective April 1, 1988)	−15	−35	−40	−90
Outpatient radiology	0	−140	−260	−400
Eye and ear hospitals	0	1	0	1
Therapeutic shoes for diabetics (demonstration)	0	0	0	0
Beneficiary co-pay for ambulatory surgery (effective April 1, 1988)	−66	−153	−180	−399
Premium extension for 1 year	0	−260	−365	−625
Rural clinics payment rate (effective April 1, 1988)	2	4	5	11
Adjustment in payment for physician services	0	0	0	0
Flu vaccine (effective October 1, 1988)	0	25	25	50
Mental health limit (effective April 1, 1988)	30	110	200	340
Psychologists in CMHCs (effective April 1, 1988)	([4])	1	2	3
Physician assistants (effective April 1, 1988)	([4])	1	2	3
NHSC physician loan collection (effective April 1, 1988)	−5	−16	−16	−37
Sequester all Part B from January 1, 1988 to April 1, 1988	−120	0	0	−120

TABLE 19.—DEFICIT IMPACT OF THE 1987 RECONCILIATION BILL BY PROVISION [1]—Continued

[By fiscal year, in millions of dollars]

	1988	1989	1990	3-year total
Sequester all part B through December 31, 1987	−50	0	0	−50
Subtotal: Part B provisions	−817	−1,652	−2,227	−4,696
D. Peer review organizations (PROs):				
Consultations and reports	1	3	3	7
On-site review requirements	0	2	2	4
Subtotal: PRO provisions	1	5	5	11
Total all medicare provisions	−2,093	−3,841	−3,888	−9,822

[1] Includes only provisions within the jurisdiction of the Committee on Ways and Means.

[2] Indicates authorizations requiring appropriations. These provisions are not included in the totals.

[3] The Department of Health and Human Services is currently preparing regulations to limit federal matching in AFDC. The delay of these regulations until fiscal year 1989 would have no cost relative to current policy or CBO's baseline. Such a delay, however, would cost $40 million a year.

[4] This indicates an amount less than $500,000.

[5] A similar provision is included in the Medicaid provisions.

Note.—Estimates assume a January 1 enactment date unless noted otherwise. The estimates also assume a Gramm-Rudman baseline. Any provisions not shown in the table have zero or insignificant budget effects.

TABLE 20.—ADMINISTRATION ESTIMATES OF CHANGES RECOMMENDED BY THE PRESIDENT FOR PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS RELATIVE TO CURRENT LAW

[In millions of dollars]

Program	1989	1990	1991	1992	1993
Medicare:					
Hospital Insurance (HI):					
Reduce indirect medical education	−920	−1,150	−1,440	−1,600	−1,730
Enforce Medicare secondary payer provisions	−10	−11	−11	−12	−12
Reduce graduate medical payments	−50	−70	−70	−80	−80
Subtotal HI	−980	−1,231	−1,521	−1,692	−1,822
Supplementary medical insurance (SMI):					
Enforce Medicare secondary payer provisions	−2	−2	−2	−2	−2
Reduce fee schedule for oxygen by 5 percent	−30	−40	−50	−60	−70
Reduce payments for radiology by 10 percent	−65	−165	−175	−200	−225
Reduce payments for anesthetists by 10 percent	−40	−70	−80	−90	−100
Fee schedules for enteral nutrients	−25	−40	−50	−60	−70
Durable medical equip. rent/purchase	−80	−130	−150	−170	−190
Eliminate reimbursement for supervision of certified nurse anesthetist	−10	−15	−20	−25	−25
Reduce reimbursement for overpriced procedures	−25	−65	−80	−90	−100
Conform payments for home dialysis	−50	−70	−100	−150	−230
Reduce graduate medical education payments	−10	−20	−20	−20	−20
Subtotal—SMI [1]	−337	−617	−727	−867	−1,032
Beneficiaries:					
Increase Part B premiums [2]	87	−335	−1,213	−1,953	−3,232
Outlay effect of additional State and local employees	0	0	0	0	0
Total, Medicare	−1,230	−2,183	−3,461	−4,512	−6,086
Medicaid impact of Medicare proposals	0	20	50	75	105
Aid to Families With Dependent Children welfare reform [3]	74	49	−51	−123	−187
Trade adjustment assistance—Eliminate program	−102	−92	−94	−96	−101
Other extension of program for IRS collection of nontax debts	−400	−400	0	0	0
Total	−1,658	−2,606	−3,556	−4,656	−6,269

[1] Estimates reflect only the effect of each proposal on SMI trust fund spending. Offsets for lower premiums due to lower program costs are reflected in the estimate of a premium increase below.

[2] Estimates assume enactment of all budget proposals which affect SMI program costs.

[3] The net cost of the Administration's welfare proposal. This assumes WIN savings of $94, $98, $101, $104 and $107 million for fiscal years 1989 to 1993 respectively.

TABLE 21.—ADMINISTRATION'S ESTIMATED BUDGET EFFECTS OF THE PRESIDENT'S REVENUE PROPOSALS, FISCAL YEARS 1988–93

[Millions of dollars]

Provision	1988	1989	1990	1991	1992	1993
Extension of Medicare payroll tax to all State and local government employees		1,615	2,100	2,140	2,170	2,190
Treatment of mutual fund shareholder expenses with respect to the 2-percent floor on miscellaneous itemized deductions		-412	-494	-593	-712	-855
Exclusion for interest on higher education savings bonds		-10	-46	-101	-150	-199
Tax credit for qualified research expenditures		-401	-816	-1,023	-1,195	-1,361
Allocation and apportionment of research expenses	-387	-625	-686	-749	-814	-887
Foreign corporation branch tax credit		-30	-53	-58	-64	-70
Modification of oil and gas depletion rules		-52	-49	-38	-19	-5
Elimination of Superfund petroleum tax differential		0	0	0	0	0
Repeal of crude oil windfall profit tax [1]	-12	-16	-10	-12	-22	-15
Repeal of tax reduction trigger for aviation excise taxes [1]			909	1,590	1,740	1,889
Customs Service user fee [2]	-18	-147	-197	484	505	486
Total	-417	-78	658	1,640	1,439	1,173

[1] Net of income offsets.

[2] Net budget impact.

Note: Only includes provisions within the jurisdiction of the Committee on Ways and Means.

Source: Treasury Department.

TABLE 22.—CBO'S ESTIMATED BUDGET EFFECTS OF THE PRESIDENT'S REVENUE PROPOSALS, FISCAL YEARS 1988–93

[Millions of dollars]

Provision	1988	1989	1990	1991	1992	1993
Extension of Medicare payroll tax to all State and local government employees		1,454	1,893	1,927	1,954	1,967
Treatment of mutual fund shareholder expenses with respect to the 2-percent floor on miscellaneous itemized deductions		−412	−494	−593	−712	−855
Exclusion for interest on higher education savings bonds		−22	−102	−213	−311	−394
Tax credit for qualified research expenditures		−401	−816	−1,023	−1,195	−1,361
Allocation and apportionment of research expenses	−387	−625	−686	−749	−814	−887
Foreign corporation branch tax credit		−30	−53	−58	−64	−70
Modification of oil and gas depletion rules		−52	−49	−38	−19	−5
Elimination of Superfund petroleum tax differential		0	0	0	0	0
Repeal of crude oil windfall profit tax [1]		0	0	0	0	0
Repeal of tax reduction trigger for aviation excise taxes [1]			885	1,591	1,752	1,914
Customs Service user fee [2]		−170	−227	360	379	364
Total	−387	−258	351	1,204	970	673

[1] Net of income offsets.

[2] Net budget impact.

Note: Only includes provisions within the jurisdiction of the Committee on Ways and Means.

Source: Congressional Budget Office.

TABLE 23.—CBO ESTIMATES OF CHANGES RECOMMENDED BY THE PRESIDENT FOR PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS RELATIVE TO CURRENT LAW

[In millions of dollars]

Program	1989	1990	1991	1992	1993
Medicare:					
Hospital Insurance (HI):					
Reduce indirect medical education	−900	−975	−1,060	−1,150	−1,250
Enforce Medicare secondary payer provisions	−10	−11	−11	−12	−12
Reduce graduate medical payments	−50	−70	−70	−80	−80
Subtotal HI	−960	−1,056	−1,141	−1,242	−1,342
Supplementary medical insurance (SMI):[1]					
Enforce Medicare secondary payer provisions	−2	−2	−2	−2	−2
Reduce fee schedule for oxygen by 5 percent	−20	−33	−38	−43	−49
Reduce payments for radiology by 10 percent	−99	−168	−198	−225	−254
Reduce payments for anesthetists by 10 percent	−57	−96	−113	−128	−145
Fee schedules for enteral nutrients	−17	−22	−24	−27	−29
Durable medical equip. rent/purchase	−94	−153	−179	−202	−228
Eliminate reimbursement for supervision of certified nurse anethetist	−10	−15	−20	−25	−25
Reduce reimbursement for overpriced procedures	−53	−90	−106	−120	−136
Conform payments for home dialysis	−52	−76	−107	−147	−201
Reduce graduate medical education payments	−10	−20	−20	−20	−20
Subtotal—SMI	−414	−675	−807	−939	−1,089
Beneficiaries:					
Increase Part B premiums [2]	97	−258	−1,027	−1,973	−3,132
Outlay effect of additional State and local employees	0	2	7	16	28
Total, Medicare	−1,277	−1,987	−2,968	−4,138	−5,535
Medicaid impact of Medicare proposals	−12	1	36	81	136
Aid to Families With Dependent Children—Welfare reform [3]	134	166	122	195	296
Trade adjustment assistance—Eliminate program	−102	−100	−103	−108	−112
Other—Extension of program for IRS collection of nontax debts	−400	−400	0	0	0
Total	−1,657	−2,320	−2,913	−3,970	−5,215

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[1] Estimates reflect only the effect of each proposal on SMI trust fund spending. Offsets for lower premiums due to lower program costs are reflected in the estimate of a premium increase below.

[2] Estimates assume enactment of all budget proposals which affect SMI program costs.

[3] The net cost of the Administration's welfare proposal. This assumes WIN savings of $96, $100, $104, $108 and $113 million for fiscal years 1989 to 1993 respectively.

TABLE 24.—CBO AND ADMINISTRATION ESTIMATES OF THE ADMINISTRATION'S BUDGET PROGRAM

[By fiscal year, in billions of dollars]

	1988	1989	1990	1991	1992	1993
	Estimates					
Revenues:						
Administration	909	965	1,044	1,124	1,190	1,258
CBO	899	955	1,038	1,113	1,182	1,262
Outlays:						
Administration	1,056	1,094	1,148	1,204	1,241	1,281
CBO	1,060	1,120	1,195	1,253	1,313	1,371
Deficit:						
Administration	147	130	104	79	51	23
CBO	161	165	157	140	131	109

Source: Congressional Budget Office; Office of Management and Budget.

TABLE 25.—THE ADMINISTRATION'S BUDGET PROGRAM AS ESTIMATED BY CBO

[By fiscal year, in billions of dollars]

	1989	1990	1991	1992	1993
CBO baseline deficit	177	170	159	154	139
Policy changes:					
Revenues [1]	−1	−1	−1	−1	−1
National defense	−1	(2)	1	3	5
Nondefense discretionary spending	−2	−2	−8	−12	−16
Entitlements and other mandatory spending	−3	−6	−6	−6	−6
Offsetting receipts	1	(2)	−4	−4	−6
Asset sales and prepayments	−6	−3	(2)	(2)	(2)
Net interest	(2)	−1	−2	−4	−5
Total policy changes	−12	−12	−19	−23	−29
Deficit, President's budget as estimated by CBO	165	157	140	131	109

[1] Revenue increases are shown with a negative sign because they reduce the deficit.

[2] Less than $0.5 billion.

Source: Congressional Budget Office.

TABLE 26.—OMB ESTIMATES OF ADMINISTRATION POLICIES FOR FISCAL YEAR 1989 USING G–R–H BASELINE

[In billions]

OMB's GRH baseline deficit	$142.7
Revenues [1]	+0.7
Outlays:	
Defense	0.0
Nondefense discretionary	
Effect on Function 950	−1.8
	+0.1
Entitlements:	
Medicare	−1.2
Medicaid	−0.4
All other	−0.2
Asset sales/loan prepayments	
Effect on Function 900	−10.0
	+0.2
Debt service	−0.6
Total deficit reduction	−13.2
President's budget deficit	129.5

[1] Lower tax collections from "feedback" effect of reducing civilian pay raise to 2 percent and delaying it until January.

Source: House Budget Committee.

TABLE 27.—COMPARISON OF CBO, ADMINISTRATION, AND PRIVATE SECTOR ECONOMIC ASSUMPTIONS

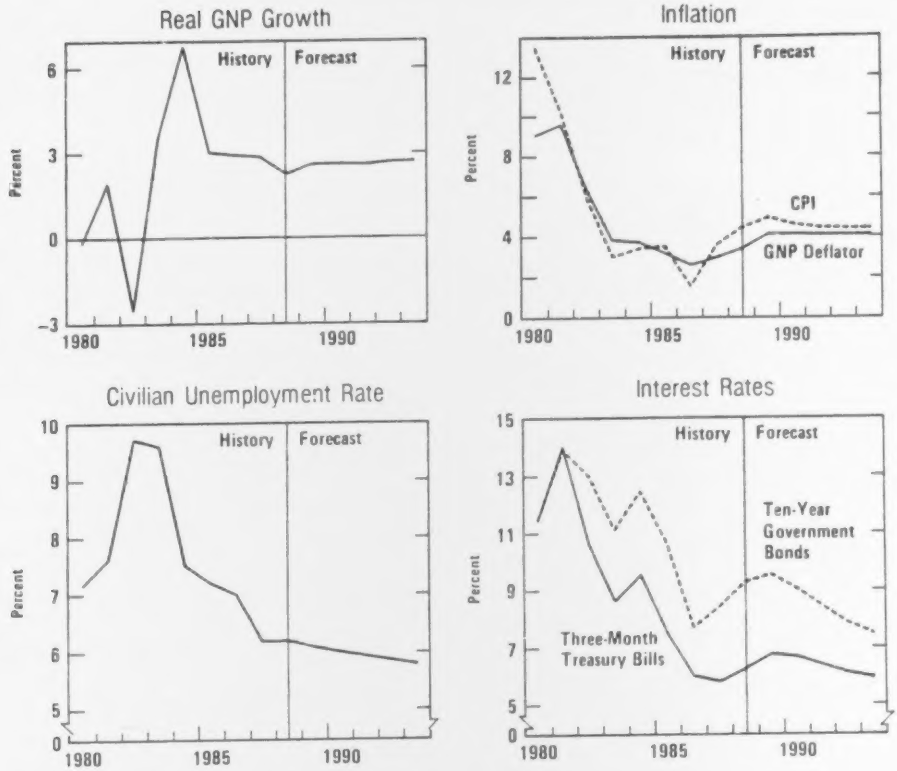
[By calendar year]

	1987	1988	1989	1990	1991	1992	1993
Nominal GNP (billions of dollars):							
CBO	4,486	4,744	5,068	5,414	5,782	6,179	6,606
Administration	4,486	4,779	5,113	5,481	5,850	6,207	6,548
DRI	4,486	4,710	5,043	5,425	5,795	6,192	6,641
Wharton	4,480	4,752	5,063	5,356	5,728	6,082	6,499
Real GNP (billions of 1982 dollars):							
CBO	3,820	3,906	4,008	4,113	4,220	4,333	4,450
Administration	3,820	3,932	4,054	4,196	4,340	4,485	4,630
DRI	3,820	3,895	4,021	4,140	4,232	4,317	4,406
Wharton	3,814	3,901	3,996	4,063	4,199	4,310	4,446
Real GNP (percent change, year over year):							
CBO	2.9	2.3	2.6	2.6	2.6	2.7	2.7
Administration	2.9	2.9	3.1	3.5	3.4	3.3	3.2
DRI	2.9	2.0	3.2	3.0	2.2	2.0	2.0
Wharton	2.7	2.3	2.4	1.7	3.3	2.7	3.1
Three-month treasury bill rate:							
CBO	5.8	6.2	6.7	6.6	6.4	6.1	5.9
Administration	5.8	5.3	5.2	5.0	4.5	4.0	3.5
DRI	5.8	5.3	6.0	6.3	6.3	6.2	6.2
Wharton	5.8	6.3	7.6	6.9	6.5	6.4	6.6
Ten-year Government note rate:							
CBO	8.4	9.3	9.5	9.0	8.4	7.8	7.4
Administration	8.4	8.0	7.4	6.8	6.0	5.0	4.5
DRI	8.4	8.1	8.4	8.6	8.6	8.7	8.7
Wharton	8.3	9.3	10.0	9.2	8.1	8.1	8.2
CPI–W (percent change, year over year): [1]							
CBO	3.6	4.5	4.9	4.6	4.4	4.4	4.4
Administration	3.6	4.3	4.1	3.6	3.2	2.7	2.2
DRI	3.6	3.9	4.6	4.9	4.7	5.0	5.2
Wharton	3.5	4.5	4.7	4.0	4.2	4.2	4.1

[1] CPI for urban wage earners and clerical workers.

Sources: Congressional Budget Office; Office of Management and Budget; Data Resources, Inc. (February 2, 1988); Wharton Econometric Forecasting Associates (February 8, 1988).

FIGURE 1.—Major CBO Economic Assumptions



Real GNP Growth

Inflation

Civilian Unemployment Rate

Interest Rates

SOURCES: Congressional Budget Office; Department of Commerce, Bureau of Economic Analysis, Department of Labor, Bureau of Labor Statistics; Federal Reserve Board.

Section 2. Description of Administration Proposals To Modify Spending for Programs Under the Jurisdiction of the Committee on Ways and Means

MEDICARE

Summit Agreement

The terms of the summit agreement were to reduce Medicare costs by $2.0 billion in fiscal year 1988 and $3.5 billion in fiscal year 1989. Stated another way, the agreement was to increase by $500 million, both in fiscal years 1988 and 1989, the level of Medicare savings contained in the reconciliation bill passed by the House of Representatives on October 29, 1987. In fact, the Medicare reductions in the reconciliation bill signed by the President on December 22 exceeded the targets set by the summit agreement. Provisions in that bill reduced Medicare spending by $2.1 billion in fiscal year 1988, $550 million more than the House-passed bill, and $3.8 billion in fiscal year 1989, over $650 million more than the House-passed bill. (See tables 18 and 19 in section 1 of Part 5).

Under the pretense that the agreement was not met, the administration has proposed an additional $1.3 billion in Medicare reductions for fiscal year 1989.

Indirect Medical Education

Current law and background:

Under the Medicare prospective payment system (PPS), teaching hospitals are paid for the indirect costs associated with approved intern and resident programs. These indirect costs may be due to a variety of reasons, such as extra demands placed on hospital staff due to the teaching activity, additional tests and procedures ordered by residents, or more severely ill patients treated at teaching hospitals. The payment adjustment is currently based on a formula that increases the Federal portion of the DRG payment by 8.1 percent. The payment amount increases depending on the ratio of interns and residents per hospital bed, as calculated on a curvilinear basis (e.g., an increase in the resident-to-bed ratio does not result in a proportional increase in payment). In fiscal years 1989 and 1990, the factor will decrease to 7.7 percent. In fiscal year 1991, the factor is scheduled to increase to 8.3 percent upon the expiration of a PPS payment adjustment for hospitals which treat a disproportionate share of low-income patients.

Description of proposal:

This proposal would reduce the factor used to calculate payments for hospital indirect medical education costs to 4.05 percent indefinitely. The factor is now 8.1 percent and is scheduled to decrease to 7.7 percent in fiscal year 1989.

Direct Medical Education

Current law and background:

The direct costs of approved medical education programs (e.g., the salaries and other education costs of interns, residents, nurses, and allied health professionals) are not included in the PPS payment rates. Instead, payments for graduate medical education are currently based on Medicare's share of each hospital's costs per resident as updated each year by the consumer price index. Direct medical education costs for the training of nurses and allied health professionals are paid on a reasonable cost basis and would not be affected by this proposal.

Description of proposal:

This proposal would limit PPS payments for the direct costs of graduate medical education (i.e., internship and residency training programs for physicians) to only those costs related to intern and resident salaries, salary-related fringe benefits, and appropriately allocated overhead. Costs for such items as classroom space and supervision by teaching physicians, which are not permitted to be included, would no longer be reimbursed.

Secondary Payer Requirements

Current law and background:

In general, Medicare is a primary payer for services to Medicare beneficiaries; that is, if a beneficiary is covered by both Medicare and another health plan, Medicare first makes payment of the claim, after which the claim is submitted to the secondary insurer for payment of any remaining amounts (e.g., Medicare deductible and coinsurance amounts). Medicare is the secondary payer, however, to employer group health plans for beneficiaries over age 65, certain disabled beneficiaries who are covered by large group health plans, and during the first year of entitlement on the basis of end-stage renal disease. Medicare is also the secondary payer to workers' compensation benefits and to automobile, liability, and no-fault insurance. A number of provisions (e.g., enforcement penalties, existence of Medicare special enrollment periods, and applicability of payments toward the Medicare deductible) vary depending on which type of health plan the primary payer is. The Federal Government may not take advantage of certain legal avenues available to private individuals in order to enforce the provisions. Under employer group health plans, Medicare is the secondary payer only if the beneficiary is employed when services are provided.

Description of proposal:

This proposal would make several modifications to the provisions in law specifying the cases in which Medicare is a secondary payer to other health plans. The proposal would (1) make the provisions more uniform (i.e., less dependent on which type of insurance plan the primary payer is), (2) give the Federal Government further legal grounds for enforcement, and (3) specify that the provisions apply whether or not a beneficiary is employed at the time services are provided.

Overpriced Procedures

Current law and background:

Under current law, Medicare payments for physician services cannot exceed the prevailing charge for the service in the community. Effective April 1, 1988, prevailing charges for the 12 surgical procedures identified by the Physician Payment Review Commission as overpriced will be reduced by 2 percent. Those prevailing charges above 85 percent of the national average will be further reduced up to 15 percent according to a sliding scale, with those charging the most subject to the highest reductions.

Description of proposal:

This proposal would reduce prevailing charges for the 12 surgical procedures by 5 percent in 1989, in addition to reductions required by current law. These procedures are perceived by the Administration to be overpriced compared to other procedures.

Radiology and Anesthesiology Payments

Current law and background:

The Secretary of Health and Human Services is required, after consulting with organizations representing radiologists and the Physician Payment Review Commission, to develop a fee schedule (i.e., a list of the services which may be provided, along with a standard charge for each service) for radiology services to be implemented by Jan. 1, 1989. The fee schedule for 1990 is required to take into account a 3 percent saving over the previous year. A final regulation and report to Congress on radiology payments are due by August 1, 1988. In addition, current law requires the Secretary, after consulting with organizations representing anesthesiologists, to develop a nationwide relative value guide for use in making payments for anesthesiology services on or after January 1, 1989. Reports to Congress on anesthesiology payments are due by January 1, 1989.

Description of proposal:

This proposal would reduce payments for radiology and anesthesiology services by 10 percent in 1989. The proposal would also delay implementation of a fee schedule for radiology services and a relative value guide for anesthesiology services until 1990.

Surgeon Supervision of CRNAs

Current law and background:

Although current law and regulations provide for reimbursement to an anesthesiologist for the supervision of certified registered nurse anesthetists (CRNAs), they do not specifically address whether an operating surgeon should be paid for the supervision of a CRNA.

Description of proposal:

This proposal would eliminate payments to a surgeon for providing medical direction to a CRNA while performing a surgical procedure.

Durable Medical Equipment

Current law and background:

Effective January 1, 1989, payment for durable medical equipment will be based on fee schedules for six different categories: (1) inexpensive and routinely purchased items; (2) customized items; (3) prosthetics and orthotics; (4) items requiring frequent servicing; (5) oxygen; and (6) other durable medical equipment items, such as wheelchairs and hospital beds, which are to be supplied on a rental basis only (with up to 15 months of rental payments). The fee schedules for all but the last category are based on average reasonable charges from a previous period. The fee schedule for items in the sixth category is based on average submitted charges.

Description of proposal:

This proposal would modify provisions regarding durable medical equipment provided on a rental basis, including wheelchairs and hospital beds. Under the proposal, the fee schedule for such items would be based on average reasonable charges, instead of average submitted charges. The proposal would allow beneficiaries the option of obtaining the items not only on a rental basis, but also on a purchase or lease/purchase basis. Under the proposal, rental payments would be limited to 12 months (after which the patient will be entitled to continued use of the equipment as long as needed) and lease/purchase payments would be limited to 15 months (after which the patient will own the equipment).

Oxygen Payments

Current law and background:

Effective January 1, 1989, payments for oxygen will be made according to a fee schedule based on 95 percent of the local average amount reimbursed by Medicare in 1986, updated by the increase in the consumer price index for the last 6 months of 1987. In subsequent years, payment rates will be updated by a full year consumer price index and regional fee schedules will be phased-in to replace local fee schedules.

Description of proposal:

This proposal would reduce payments for oxygen by an additional 5 percent.

Home Dialysis

Current law and background:

Medicare home dialysis patients may choose to be paid in two different ways. Either (1) the patient may receive the equipment and supplies from a facility which is paid based upon a national average composite rate, or (2) the patient may receive the equipment and supplies directly from a supplier, in which case the beneficiary would be paid on a reasonable charge basis.

Description of proposal:

This proposal would require Medicare beneficiaries who receive home dialysis equipment and supplies directly from a supplier to enter into an agreement with one supplier who will furnish all of the necessary equipment and supplies; the supplier would be required to agree to accept payment based on the national average composite rate for home dialysis treatment. In addition, the proposal requires beneficiaries to enter into an agreement with a local facility that will furnish all necessary home dialysis support services, including any necessary in-facility dialysis.

Enteral Products and Supplies

Current law and background:

Medicare payment for enteral products and supplies is made at the lowest of the (1) actual charge, (2) customary charge, (3) prevailing charge, (4) lowest charge level, or (5) inflated-index charge. Patients who rely on enteral products and supplies are those who, as a result of chronic illness or trauma, cannot be sustained by oral feeding.

Description of proposal:

This proposal would pay for enteral nutrition products and supplies based on a fee schedule. The payment would be the lower of the (1) submitted charge, or (2) fee schedule amount based on the lower of (a) current lowest charge level limits, or (b) national payment limits derived from wholesale and retail price information.

Part B Premium

Current law and background:

Medicare beneficiaries are required to pay a premium for Part B services. From 1984 through 1989, the premium has temporarily been set at 25 percent of program costs for aged beneficiaries. The remaining 75 percent is covered by general revenues of the Federal government. In 1990, however, the method for calculating the premium will be the same as the one used before 1984; that is, increases in the premium will be limited by the Social Security cost of living adjustment. Beneficiaries are responsible for a monthly premium of $24.80 in 1988.

Description of proposal:

This proposal would require beneficiary Part B premiums to be permanently set at a rate which will cover 25 percent of the program costs of aged beneficiaries. The proposal will not have any effect on Medicare revenues in fiscal year 1989.

Impact:

PART B PREMIUM PROJECTIONS[1]

	Calendar year—						
	1987	1988	1989	1990	1991	1992	1993
	Administration estimates						
Current law	17.90	24.80	28.00	29.20	30.40	31.50	32.50
Proposed law		24.80	27.70	30.50	34.00	36.70	41.20
Difference			—.30	1.30	3.60	5.20	8.70
	CBO estimates						
Current law	17.90	24.80	27.10	28.30	29.70	31.00	32.40
Proposed law		24.80	26.70	29.30	32.80	36.50	40.70
Difference			—.40	1.00	3.10	5.50	8.30

[1] These premium amounts reflect only current law or proposals in the fiscal year 1989 budget. They do not take into consideration any other future program changes such as Catastrophic Health Insurance.

Other Medicare Related Initiatives

In addition to the proposals described above, the President's fiscal year 1989 budget contains the following requests for increased funding for peer review organizations and administration and research, and a proposal for a contingency fund in anticipation of the enactment of a catastrophic health insurance plan under Medicare:

Peer Review Organizations.—The President's fiscal year 1989 budget requests $322 million for Medicare peer review organizations (PROs), an increase of $131 million over the previous year. PROs review the medical services provided to Medicare patients to assure that services are medically necessary, provided in the appropriate setting, and meet professionally recognized standards of quality health care. The additional money is intended to expand PRO review of health maintenance organizations and competitive medical plans, ambulatory surgical procedures, readmissions, and beneficiary complaints.

Administration and Research.—The President's fiscal year 1989 budget also makes funding requests for the Health Care Financing Administration's (HCFA) administration and research activities. While such activities may include those concerning the Medicaid program, much of the following requests are directed toward management of the Medicare program:

Research, Demonstrations, and Evaluation.—The fiscal year 1989 budget requests $32 million for HCFA's research, demonstration, and evaluation program, an increase of $5 million over the previous year. The Administration indicates that its priorities in this area include increased competition, quality of care, and alternative payment systems.

Medicare Contractors.—The fiscal year 1989 budget requests $1.3 billion for Medicare contractors, an increase of $168 million over the previous year. Many of the program's operations (e.g., reviewing and paying claims) are performed by organizations, such as Blue Cross/Blue Shield and private insurers, often referred to as Part A intermediaries and Part B carriers. The Administration says increased funding is needed to deal with a growing number of Medicare claims, strengthen payment safeguard activities, and invest in improvements in productivity.

Medicare State Survey and Certification.—The fiscal year 1989 budget requests $66 million for Medicare's State survey and certification program, the same funding level provided in the previous year. The program is responsible for certifying that providers of services to Medicare beneficiaries meet acceptable health and safety standards. The Administration says this funding level will allow it to survey new providers, survey a sample of existing providers, and provide follow-up monitoring of facilities having deficiencies in previous surveys.

Federal Administrative Costs.—The fiscal year 1989 budget requests $271 million for Federal administrative costs, an increase of $13 million over the previous year. The request includes funding for 4,096 employees (an increase of 236 over the previous year), including 50 to manage the anticipated Catastrophic Health Insurance Trust Fund. The request also includes funding for improved computer systems.

Catastrophic Health Insurance.—The President's fiscal year 1989 budget requests a $112 million contingency fund for the implementation of a catastrophic health insurance plan under Medicare if it is enacted. The Administration would use this funding for personnel and claims processing costs.

AID TO FAMILIES WITH DEPENDENT CHILDREN AND CHILD SUPPORT ENFORCEMENT

The Administration's fiscal year 1989 budget request does not propose new statutory changes in either the Aid to Families with Dependent Children (AFDC) or Child Support Enforcement (CSE) programs. Instead, the Administration has included in its budget request $168 million in increased outlays in fiscal year 1989 for the costs of H.R. 3200, the AFDC Employment and Training Reorganization Act of 1987. H.R. 3200 is the welfare reform bill supported by President Reagan. (The House-passed welfare reform bill is H.R. 1720, the Family Welfare Reform Act of 1987.)

H.R. 3200 would reform AFDC work and training programs, strengthen the Federal-State child support enforcement system and provide broad flexibility to States to test alternatives to current programs which support low-income families and individuals.

TRADE ADJUSTMENT ASSISTANCE

Worker Program

No funding of program in fiscal year 1989; replace with proposed new consolidated worker adjustment assistance program

Current law and background:

Under the Trade Act of 1974 as amended, workers certified by the Secretary of Labor as eligible for trade adjustment assistance (TAA) may receive weekly trade readjustment allowances (TRA) equal to their weekly unemployment compensation (UC) after they exhaust UC for up to a combined maximum of 52 weeks of UC and TRA. Workers enrolled in approved training, however, may receive up to an additional 26 weeks of TRA immediately following exhaustion of their regular TRA in they are enrolled in or have completed an approved job search program. Job search and relocation allowances are also available to qualified workers. The program was reauthorized under the Consolidated Omnibus Budget Reconciliation Act of 1985 for six years through September 30, 1991.

The Administration's estimated funding levels for the current program are based on the following number of recipients and average level and duration of benefits:

CURRENT PROGRAM

Year	Outlays (millions)	Numbers of recipients (thousands)	Average weekly benefit	Weeks duration
1980	1,622	532	126	24
1981	1,440	281	140	37
1982	103	30	119	28
1983	37	30	120	10
1984	35	16	139	16
1985	43	20	133	15
1986	116	40	144	19
1987 (estimated)	198	50		

Note: Outlay figures shown above are for cash entitlement portion of the program; an additional $47.9 million is funded for training and job search and relocation allowances in fiscal year 1988.

Description of proposal:

The existing programs now providing job search, job training, and cash benefits to dislocated workers under TAA and Title III of the Job Training Partnership Act (JTPA) are proposed to be eliminated and replaced by a new consolidated Worker Readjustment Program. This new program would assist all dislocated workers without regard to whether they are unemployed because of increased imports, or due to other causes. Services would include counseling, job search assistance, basic education, and job skill training. States would be responsible for operating the programs, which would be linked to the unemployment insurance system, with the private industry councils set up under JTPA given local oversight responsibilities.

Impact:

The Administration is requesting $980 million for the new program in fiscal year 1989 to service about 700,000 workers, of which, about $500 million represents funds in addition to the $475 million appropriated in fiscal year 1988 for the current TAA and JTPA dislocated worker programs. Income support payments under the proposed new program cannot exceed 15 percent of the total funds available to the State.

Firm Program

No funding of program in fiscal year 1989

Current law and background:

Under the Trade Act of 1974 as amended, firms certified eligible by the Secretary of Commerce for trade adjustment assistance may receive technical assistance upon approval of an adjustment plan. Industrywide technical assistance grants are also available. The program was reauthorized under the Consolidated Omnibus Budget Reconciliation Act of 1985 for 6 years until September 30, 1991.

Description of proposal:

The Administration requests no funding of the program in fiscal year 1989. About $14.4 million has been appropriated for the program in fiscal year 1988.

DEBT COLLECTION

Extension of Program for Collection of Nontax Debts Owed to Federal Agencies

Current law and background:

Federal agencies are authorized to inform the IRS that a person (who has received proper notification from the agency) owes a past due, legally enforceable, debt to the agency. The IRS then must reduce the amount of any tax refund due the person by the amount of the debt and pay that amount to the agency. The refund offset applies to individuals and corporations. This program is scheduled to expire after June 30, 1988.

Description of proposal:

The baseline in the President's budget proposal assumes that this program will be extended through December 31, 1990.

Section 3. Administration's Revenue Proposals

The administration's fiscal year 1989 budget includes a number of revenue proposals that were contained in earlier budgets, and some new proposals. Together, the administration's proposals would increase revenues by $2.0 billion over the 1989–91 period.

Extension of Medicare Payroll Tax to All State and Local Government Employees

Present law

Before enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (P.L. 99–272), State and local government employees were covered for Social Security and Medicare benefits only if the State and the Secretary of Health and Human Services (HHS) entered into a voluntary agreement providing such coverage. In COBRA, the Congress extended Medicare coverage (and the corresponding hospital insurance payroll tax) on a mandatory basis to State and local government employees hired after March 31, 1986, for services performed after that date. Under present law, State and local government employees hired before April 1, 1986, still are not covered for Medicare unless a voluntary agreement is in effect. See table 4 in the Social Security financing section for the percentage of State and local jobs covered under Social Security for each State. Currently, about 70 percent of all State and local government employees are covered under a voluntary agreement. Of the group not covered either on a voluntary or mandatory basis, it is estimated that approximately 75 percent ultimately receive Medicare coverage because of eligibility through a spouse or as a result of other covered employment. Medicare coverage (and the hospital insurance payroll tax) is mandatory for Federal employees.

For wages paid in 1988 to Medicare-covered employees, the total hospital insurance tax rate is 2.9 percent of the first $45,000 of wages (Code secs. 3101, 3111, and 3121). One-half of this tax is paid by the employee and one-half by the employer.

President's budget proposal

The President's budget proposal would extend Medicare coverage on a mandatory basis to all employees of State and local governments not otherwise covered under present law, without regard to their dates of hire. These employees and their employers would become liable for the hospital insurance portion of the FICA tax, and the employees would earn credit toward Medicare eligibility based on their covered earnings.

This proposal would be effective December 1, 1988.

Treatment of Mutual Fund Shareholder Expenses With Respect to the 2-Percent Floor on Miscellaneous Itemized Deductions

Present law

For taxable years beginning after December 31, 1986, miscellaneous employee and investment expenses are generally deductible by individuals only to the extent that such expenses exceed 2 percent of adjusted gross income. Under the Tax Reform Act of 1986, this 2-percent floor applies with respect to indirect deductions through regulated investment companies (mutual funds), i.e., certain investment expenses of such funds that would otherwise reduce shareholder taxable income are treated as miscellaneous deductions of individuals and subjected to the 2-percent floor at the shareholder level.

The Omnibus Budget Reconciliation Act of 1987 (OBRA) delays treatment of shareholder expenses of publicly offered mutual funds as miscellaneous deductions of individuals until taxable years beginning after December 31, 1987.

President's budget proposal

The President's budget proposal would permanently exempt shareholder expenses of publicly offered mutual funds from treatment as miscellaneous itemized deductions of individuals.

The proposal would be effective January 1, 1988.

Exclusion of Interest on Higher Education Savings Bonds

Present law

There are no provisions in the present-law Federal individual income tax which exempt gross income or provide a tax deferral for interest income or other amounts that may be invested to fund post-secondary school educational expenses.

Certain types of income from savings arrangements are exempt from gross income or are not currently included in gross income of a taxpayer. For example, interest income on qualified State and local government bonds generally is exempt from Federal income taxation. Income credited to life insurance or annuity contracts (i.e., inside buildup) is not taxed until distributed to the policyholder, and is not taxed if paid to a designated beneficiary after the death of the insured individual (in the case of a life insurance contract).

In addition, taxation of the income earned on amounts contributed to an individual retirement arrangement (IRA) or an employer-maintained qualified pension plan is deferred until the amounts are distributed to the owner of the IRA or to the employee participating in the employer-maintained plan. Generally, amounts distributed prior to the attainment of age 59½ are subject to an additional 10-percent early withdrawal tax.

Taxation of interest accruals on Series EE savings bonds may be deferred by cash-basis taxpayers as long as the bonds are not redeemed.

President's budget proposal

The President's budget proposal would exclude from Federal income taxation the interest on certain savings bonds that are redeemed to pay certain post-secondary school educational expenses of the taxpayer or the taxpayer's spouse, children, or other dependents. The exclusion would be phased out for taxpayers with adjusted gross income above certain levels; the phase-out levels would be adjusted annually for inflation beginning in 1990. The amount of interest eligible for the exclusion would be limited to the total qualified educational expenses incurred.

The exclusion would apply to bonds issued after December 31, 1988.

Tax Credit for Qualified Research Expenditures

Present law

The Tax Reform Act of 1986 extended the tax credit for qualified research expenditures for three years (i.e., through December 31, 1988) and reduced the credit rate from 25 percent to 20 percent.

Except for certain university basic research payments, the credit applies only to the extent that the taxpayer's qualified research expenditures for the taxable year exceed the average amount of the taxpayer's yearly qualified research expenditures in the specified base period, which generally is the preceding three taxable years. Eligible expenditures consist of: (1) "in-house" expenditures by the taxpayer for research wages and supplies used in research; (2) certain time-sharing costs for computer use in research; and (3) 65 percent of amounts paid by the taxpayer for contract research conducted on the taxpayer's behalf. The 1986 Act provided a more explicit and targeted definition of research expenditures eligible for the credit.

Under the 1986 Act, the 20-percent tax credit also applies to the *excess* of (1) 100 percent of corporate cash expenditures (including grants or contributions) paid for university basic research *over* (2) the sum of (a) the greater of two fixed research floors plus (b) an amount reflecting any decrease in nonresearch giving to universities by the corporation as compared to such giving during a fixed base period, as adjusted for inflation.

President's budget proposal

The President's budget proposal would make permanent the 20-percent tax credit for qualified research expenditures.

Allocation and Apportionment of Research Expenses

Present law

Computation of the foreign tax credit requires the taxpayer to distinguish between taxable income from U.S. sources and taxable income from foreign sources, and thus to allocate and apportion deductions among items of U.S.-source and foreign-source gross income. Treasury regulations prescribe a detailed method for allocating and apportioning research and experimental (R&D) expenses for this purpose, among others.

Effective for taxable years beginning after August 13, 1981, and on or before August 1, 1987, the R&D allocation regulation was suspended (for purposes of determining the source of taxable income) by a succession of statutes: the Economic Recovery Tax Act of 1981 (ERTA), the Deficit Reduction Act of 1984 (DEFRA), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and the Tax Reform Act of 1986 (TRA). In taxable years governed by ERTA, DEFRA, and COBRA, all U.S.-incurred R&D expenses were allocated to U.S.-source income. In taxable years governed by TRA, 50 percent of such expenses (other than amounts incurred to meet certain legal requirements, and thus allocable to one geographical source) were allocated to U.S.-source income, with the remainder allocated and apportioned either on the basis of sales or gross income.

President's budget proposal

For tax years beginning after August 1, 1987, taxpayers could allocate at least 67 percent of expenses for R&D to U.S. source income.

Foreign Corporation Branch Tax Credit

Present law

The United States generally imposes a flat rate tax on dividends paid by U.S. corporations to foreign shareholders. The statutory flat rate is 30 percent, but income tax treaties sometimes require the United States to reduce the rate to as little as 5 percent. When a foreign corporation operates here, the United States generally imposes a "branch profits tax", which is a surrogate for the flat dividend tax, on the profits that the foreign corporation takes out of the United States.

When a foreign corporation that has borne one of these U.S. taxes (the foreign corporation having received a dividend from a U.S. corporation or having paid a branch profits tax) pays a dividend to a U.S. shareholder, the U.S. shareholder does not receive credit for the U.S. tax previously paid with respect to this income. Thus, the U.S. tax borne by the foreign corporation is in effect deductible rather than creditable, because it reduces the amount of dividend that the foreign corporation can pay.

Ten percent or greater U.S. corporate shareholders in foreign corporations may deduct a fraction (generally 70 percent) of dividends attributable to the payor's U.S. income.

President's budget proposal

The President's budget proposal would provide a tax credit to U.S. shareholders of foreign corporations for U.S. branch taxes paid by the foreign corporations for U.S. withholding taxes imposed on dividends paid to the foreign corporations. The proposal would also extend the dividends received deduction to less than 10 percent U.S. corporate shareholders in foreign corporations.

Modification of Oil and Gas Percentage Depletion Rules

Present law

Under present law, independent oil producers and royalty owners (but not integrated oil companies) recover certain costs incurred prior to drilling an oil- or gas-producing property using the higher of cost or percentage depletion. Under percentage depletion, 15 percent of the taxpayer's gross income from an oil- or gas-producing property is allowed as a deduction in each taxable year. The amount deducted may not exceed 50 percent of the taxable income from the property for the taxable year, computed without regard to the depletion deduction (the "net income limitation"). Additionally, the deduction for all oil and gas properties may not exceed 65 percent of the taxpayer's overall taxable income (determined with certain adjustments).

In addition, percentage depletion for oil and gas properties for independent producers and royalty owners is limited to 1,000 barrels of average daily domestic crude oil production (or an equivalent amount of natural gas). If an interest in a proven oil or gas property is transferred after 1974, production from that interest generally does not qualify for percentage depletion.

President's budget proposal

The President's budget proposal would increase the net income limitation from 50 percent to 100 percent.

In addition, the President's budget proposal would repeal the percentage depletion anti-transfer rules.

The proposals would be effective January 1, 1989.

Elimination of Superfund Petroleum Tax Differential

Present law

Superfund taxes of 8.2 cents per barrel for domestic crude oil and 11.7 cents per barrel for imported petroleum products (including crude oil) are imposed on the receipt of crude oil at a U.S. refinery, the import of petroleum products and, if the tax has not already been paid, on the use or export of domestically produced oil.

Domestic crude oil subject to tax includes crude oil condensate and natural gasoline, but not other natural gas liquids. Taxable crude oil does not include oil used for extraction purposes on the premises from which it was produced, or synthetic petroleum (e.g., shale oil, liquids from coal, tar sands, biomass), or refined oil.

Petroleum products which are subject to tax upon import include crude oil, crude oil condensate, natural and refined gasoline, refined and residual oil, and any other hydrocarbon product derived from crude oil or natural gasoline which enters the United States in liquid form.

The petroleum tax generally expires on December 31, 1991. The tax will terminate earlier than that date if cumulative Superfund receipts during the reauthorization period equal or exceed $6.65 billion, and under certain other conditions.

Canada, Mexico, and the European Community filed a formal complaint under the General Agreement on Tariffs and Trade ("GATT") after the Superfund tax on imported oil was raised above that on domestic oil by the Superfund Amendments and Reauthorization Act of 1986. A GATT panel convened to investigate the complaint, concluded that the differential petroleum tax rate is contrary to the GATT, and the panel ruling was accepted unanimously by the GATT Council on June 17, 1987. Under GATT rules, the United States either must amend the Superfund tax or compensate the plaintiffs to avoid possible retaliation.

President's budget proposal

The President's budget proposes a revenue neutral change in the Superfund excise taxes on domestic crude oil and imported petroleum products (including crude oil): increasing the rate on domestic crude oil (presently 8.2 cents per barrel) and lowering, to an equal level, the rate on imported petroleum products (presently 11.7 cents per barrel).

Repeal of the Crude Oil Windfall Profit Tax

Present law

An excise tax is imposed on the windfall profit element of the price of domestically produced crude oil when it is removed from the premises on which it was produced. The windfall profit is defined as the excess of the sale price over the sum of the adjusted base price (adjusted for inflation and for grade, quality, and field) plus the applicable State severance tax adjustment.

The tax rates and recent base prices applicable to taxable crude oil are as follows:

Category of oil	Tax rate (percent)	Adjusted base price [1] (dollars per barrel)
Tier-1 oil (oil not in tiers 2 or 3):		
Integrated producer	70	$18.84
Independent producer	50	19.44
Tier-2 oil (stripper and petroleum reserve):		
Integrated producer	60	21.99
Independent producer [2]	30	NA
Tier-3 oil:		
Newly discovered oil [3]	20	28.54
Incremental tertiary oil	30	28.07
Heavy oil	30	23.91

[1] Estimate of average adjusted base price for third quarter of 1987.

[2] Independent producer stripper well oil is exempt from tax.

[3] Rate phases down to 15 percent in 1989.

NA—Not available.

The tax is scheduled to phase out over a 33-month period beginning no later than January 1991.

President's budget proposal

The President's budget proposal would repeal the windfall profit tax.

Repeal of Tax Reduction Trigger for Aviation Excise Taxes

Present law

Excise taxes are imposed on air passenger tickets (8 percent), domestic air freight (5 percent), international passenger departures ($3), and fuels for noncommercial aviation (12 cents per gallon on gasoline and 14 cents per gallon on other fuels). The Airport and Airway Revenue Act of 1987 (the 1987 Act) extended these taxes through December 31, 1990.

Revenues from the aviation excise taxes are transferred to the Airport and Airway Trust Fund to finance Federal airport and airway programs. The 1987 Act provides for an automatic 50-percent reduction ("tax reduction trigger") in the aviation excise taxes (other than the $3 departure tax) in calendar year 1990, if the total appropriations for fiscal years 1988 and 1989 for airport improvements, facilities and equipment, and research, engineering and development are less than 85 percent of the total amounts authorized for these three programs for fiscal years 1988 and 1989.

President's budget proposal

The President's budget proposal would repeal the aviation "tax reduction trigger" for 1990. CBO and the Administration project that appropriated and obligated amounts will fall short of the threshold, triggering the reduction in rates. Thus, extension of the taxes at current rates will increase airport and airway taxes by approximately $6.1 billion over the 1990–93 period.

Private Mediation of Tax Controversies

Present law

When a taxpayer receives notice from the IRS that it has determined a deficiency of tax, the taxpayer may, before paying the deficiency, petition the United States Tax Court within 90 days after the notice of deficiency was mailed for a redetermination of the deficiency. This jurisdiction is provided by section 6213 of the Internal Revenue Code of 1986.

At the option of the taxpayer and the concurrence of the Tax Court, income tax disputes involving less than $10,000 for any one taxable year can proceed through the Tax Court pursuant to special "small tax case rules," which provide for expedited pretrial procedures and trials conducted as informally as possible consistent with orderly procedure. Neither the taxpayer nor the Government may appeal the decision of the trial judge in a small tax case.[1]

As an alternative to filing a petition in Tax Court, the taxpayer may pay the deficiency and file a claim for refund of the disputed amount with the IRS. If the IRS rejects the refund claim, or does not act within six months, then the taxpayer may bring an action for refund in Federal district court or the United States Claims Court, but not the Tax Court. This jurisdiction is provided by 28 U.S.C. sections 1346(a)(1) and 1491. There is no statutory authority for resolution of tax disputes in any forum other than these three courts, once the IRS has determined that a deficiency exists.

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[1] Sec. 7463 and Tax Court Rules 171–179.

As of February 1988, the Tax Court had a backlog of over 74,000 pending cases, which is approximately three times the number of Tax Court cases pending in 1978.[2] Recently, however, the backlog of pending Tax Court cases has been diminishing: in February 1987, 83,000 cases were pending before the Tax Court. Currently, there is no significant backlog of small tax cases in Tax Court.

President's budget proposal

The Budget Message of the President states: "The Federal Government should also depend more on the private sector to provide ancillary and support services for activities that remain in Federal hands. Therefore, I am proposing the development of a private mediating institution to reduce the backlog of cases before the U.S. Tax Court." [3]

Customs Service User Fee

Present law

An ad valorem user fee is applied to all formal entries of merchandise imported for consumption. The fee, which currently is 0.17 percent of value, is scheduled to expire after September 30, 1990. The user fee is intended to provide revenue equal to the costs of the Customs Service commercial operations.

In the Omnibus Budget Reconciliation Act of 1987, collections from the fee were reclassified as offsets to outlays, rather than as receipts. For imported goods made with U.S. components, the Act exempted only the value of the U.S. component from the fee, rather than the total value of the good. A ruling of the General Agreement on Tariffs and Trade (GATT) indicates that correcting legislation is needed to make the user fee consistent with GATT requirements.

President's budget proposal

Legislation will be proposed to ensure that the ad valorem fee structure represents the costs of processing individual entries and that collections from the fee are reclassified as budget receipts. The President also proposes to extend the fee through 1993.

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[2] During the same time period, the number of tax returns filed increased by approximately 22 percent.

[3] United States Budget in Brief, Fiscal Year 1989, The Budget Message of the President, at 12.

Section 4. Description of the Balanced Budget and Emergency Deficit Control Act of 1985 as Amended (Gramm-Rudman-Hollings)

OVERVIEW

"The Balanced Budget and Emergency Deficit Control Act of 1985" (referred to as the "Act") mandates annual budget deficit reductions in order to achieve a balanced budget by 1991 (later amended to 1993).

The principal enforcement mechanism of the Act is "sequestration," a procedure requiring automatic reductions in Federal spending programs in the event that annual deficit targets are not met by congressional action.

On February 7, 1986, a special three-judge panel of the U.S. District Court ruled that the role of the Comptroller General in the preparation of "sequestration" reports was unconstitutional as it violated the principle of separation of powers. This ruling was upheld by the Supreme Court on July 7, 1986. According to the Court, the powers conferred upon the Comptroller General are executive powers which cannot constitutionally be exercised by an officer removable by Congress.

To correct the constitutionally flawed Act, Congress passed the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987 (P.L. 100-119) reinstating automatic sequestration through 1993 and providing the Office of Management and Budget (OMB) with responsibility for the reports that are the basis of the Presidential sequestration orders. The law's maximum deficit amounts (MDAs) or "targets" were also adjusted to achieve a balanced budget by 1993.

MAXIMUM DEFICIT AMOUNTS

[In billions of dollars]

Fiscal year:	
1988	144
1989	136
1990	100
1991	64
1992	28
1993	0

If the deficit is estimated to exceed the maximum level by any amount in 1993, or by more than $10 billion in 1989-1992, an automatic spending reduction procedure is triggered to eliminate the excess deficit through the sequestration of budgetary resources. Except for trust and special funds, this involves the permanent cancellation of new budget authority and other authority to obligate and expend funds.

In 1988, the law limited sequestration to $23 billion. In 1989, sequestration will occur if the deficit is greater than $146 billion ($136 billion MDA plus the $10 billion margin) and the net reduction of the deficit excess between January 1, 1988, and October 10, 1988, has been less than $36 billion. Whether sequestration actually takes place will depend entirely upon OMB's determination of the deficit on August 25 and October 15. The economic and technical assumptions are projected on July 15 and cannot change thereafter in either the August or October report. All assumptions become known in the August 25 OMB report and may not change when estimating the deficit on October 15. Only changes in law enacted and regulations promulgated as final between August 25 and October 15 can change the August 25 estimate of the deficit. For fiscal year 1989, sequestration is limited to the lesser of the amount needed to reach the target, or $36 billion. For the remaining years 1990-1993, sequestration equals the amount needed to reach the MDA.

Sequestration may only be triggered once per fiscal year and any sequestration order issued remains in effect for that fiscal year only. COLA reductions last for one year from the time the reduction takes place, and there are no catch-up provisions. (COLAs were last reduced in 1986 and are now largely exempt.) The process must start all over again to determine whether a sequestration order would be issued in the next fiscal year.

SEQUESTRATION TIMETABLE

Unlike the original law, the revised Act requires separate reports from OMB and the Congressional Budget Office (CBO) regarding the level of the deficit and the amount of required sequestration. The timetable for the entire process is shown in table 1.

Prior to the reports, the President must notify Congress (by August 15), if he intends to use authority given him in the Act to exempt military personnel from sequestration. Then, on August 20 and 25 respectively, CBO and OMB issue initial sequestration reports on the deficit and MDA based on laws and regulations promulgated as final on August 15. With the Comptroller General no longer involved in issuing the order, CBO's report is made to the Congress and OMB. Congress and the President receive the report from OMB. Because the President's sequestration order is based on OMB's determinations, the role of CBO has become more advisory.

The report contains the following for such fiscal year:

1. The estimated levels of total outlays and total revenues, the amount of any excess deficit, and whether such excess is greater than $10 billion (zero in fiscal year 1993), and for 1989, the amount of net deficit reduction since January 1, 1988 and whether the reduction is more than $36 billion.

2. The estimated rate of real economic growth (for each quarter of such year and for each of the last two quarters of the preceding

year); and whether negative real economic growth for two or more consecutive quarters will occur.

3. The base from which reductions (sequestrations) are to be made (if the deficit is $10 billion over the MDA [$0 in fiscal year 1993]) by account and by program, project, and activity (PPA) within each account for defense; and the amounts and percentages by which such accounts and PPAs must be reduced during such fiscal year to eliminate the excess.

4. The amount of automatic spending increases (COLAs) which are scheduled to take effect in programs with such increases, the amount and percentage by which such increases are to be reduced, the amount of deficit excess eliminated by such reductions, and the percentage (if any) of such increases after the reductions.

5. The amount of savings achieved in programs with special rules.

On August 25, the President must issue the sequestration report or issue the same order indicating no reductions are needed. The order is to be precisely based on the OMB director's August 25 findings. The reductions begin at the start of the fiscal year, October 1.

The President must transmit to Congress a message containing the same information as required in the OMB report, and specifying within each defense and nondefense account for each program, project or activity, or budget account activity, the base from which such sequestration is made and the amounts which are to be sequestered from each PPA. The President may also submit such other supporting details as he deems appropriate. This message is referred to all committees with jurisdiction over programs, projects, and activities affected by the order.

On October 10, CBO issues a final report. OMB makes its report on the 15th. Both are based on final laws and regulations in effect as close as possible to the report day.

On October 15, the President issues the final budget reductions based on OMB's findings. However, within 15 days after the order he may propose to Congress a plan to permit greater flexibility within the defense budget to accommodate the sequestration cuts. He may also send his alternative to sequestration. The President cannot use the defense flexibility unless Congress enacts it into law.

The Comptroller General continues to retain an auditing role in the amended law. By November 15, the Comptroller General must certify that the President and OMB complied with the law. He may make suggestions for improving the sequestration process.

In the revised Act, Congress retained several alternative responses to sequestration. Two days after the final OMB report, the Senate may begin producing an alternative to sequestration similar to a fast track reconciliation bill. This has never been used.

In addition, the amended law now permits the leaders of both Houses to introduce a joint resolution amending or eliminating sequestration up to 10 days after the last OMB report. It may proceed through Congress as a privileged bill on a somewhat expedited basis but still requires a Presidential signature.

The 1987 revision retained the procedures of the Temporary Joint Committee on Deficit Reduction which may issue the report triggering the sequestration order if any part of the reporting process is ruled unconstitutional. Within 5 calendar days after receiving the CBO report, the Temporary Joint Committee on Deficit Reduction must report a joint "sequester" resolution setting forth the contents of the CBO report without change. The House and Senate are required to act on this joint "sequester" resolution within 5 legislative days of its having been reported. Upon enactment of the joint resolution, the President is required to issue a sequester order that conforms to the matter in the joint resolution. It must eliminate the full amount of the excess deficit in strict accordance with the requirements of the Act, e.g. special rules, exempted program, 50/50 defense/nondefense split.

At any time, the Congress may suspend, by joint resolution, the entire Gramm-Rudman Act if recessionary conditions exist as specified by the law. If either CBO or OMB projects real economic growth at less than zero for two consecutive quarters or if the Department of Commerce reports two quarters of actual growth to be less than 1 percent, the conditions are met.

TABLE 1.—TIMETABLE FOR SEQUESTRATION PROCEDURES

Action	Fiscal year—	
	1988	1989–1993
Date from which deficit reduction is measured.	January 1	January 1.
President submits to Congress the mid-session budget report (establishing the economic and technical assumptions to be used in sequestration).	Not applicable	July 15.
Presidential notification regarding military personnel accounts.	October 10	August 15.
Initial OMB/CBO snapshot	October 10	August 15.
CBO issues its initial report to OMB and Congress.	October 15	August 20.
OMB issues its initial report to the President and Congress.	October 20	August 25.
President issues initial order	October 20	August 25.
President transmits to Congress a detailed message regarding the initial order.	Within 15 days after the order is issued.	Within 15 days after the order is issued.
Fiscal year begins and initial order becomes effective.	October 1 (order becomes effective on date issued).	October 1.
CBO issues its revised report to OMB and Congress.	November 15	October 10.
OMB issues its revised report to the President and Congress.	November 20	October 15.
President issues final order (which becomes effective immediately).	November 20	October 15.

TABLE 1.—TIMETABLE FOR SEQUESTRATION PROCEDURES—Continued

Action	Fiscal year—	
	1988	1989–1993
Majority Leader in each House shall introduce a joint resolution which affirms any modifications in defense programs proposed in the President's notification report if the report is timely submitted (the joint resolution is considered under expedited procedures and is amendable).	Introduced within 5 session-days after report is submitted by President (but before November 25).	Introduced within 5 session-days after report is submitted by President (but before October 20).
Majority Leader in each House may introduce a joint resolution which modifies the final order (the joint resolution is considered under expedited procedures and is amendable).	Introduced within 10 session-days after revised OMB report is submitted.	Introduced within 10 session-days after revised OMB report is submitted.
President transmits to Congress a detailed message regarding the final order.	Within 15 days after the order is issued.	Within 15 days after the order is issued.
Comptroller General issues compliance report.	December 15	November 15.

SEQUESTRATION

"Sequestration" is the formula reduction of "budgetary resources" required by the Act. It occurs, once each fiscal year, if and only if OMB projects that the MDA will be exceeded by more than a specified margin. The margin is $10 billion in fiscal 1989–1992 and zero in fiscal 1993.

Half the reductions are taken from defense and a half from nondefense. The reductions are translated into percentages that are applied to the budgetary accounts.

THE BUDGET BASELINE

The baseline calculations, consisting of spending and tax laws, and driven by economic and other estimating factors, determine total outlays, revenues, and the deficit.

The Reaffirmation Act of 1987 requires two sets of baselines in order to determine (1) the amount of unachieved deficit reduction and (2) the excess over the target. The first baseline is constructed in January and the second on the snapshot dates in either August or October. The changes between the two measures the effects of new laws and final regulations. The only exception are Federal pay raises which are scored differently in each base.

The revised law's baselines resemble the OMB's current services and CBO's baseline projections. The Congress also resolved a number of technical differences between OMB and CBO and restricted the deviations OMB can make from certain CBO estimates.

In constructing the baselines, the following rules are employed:

1. Only enacted law is considered. The Directors do not attempt to anticipate the outcome of legislation still working its way

through Congress. Enacted entitlement law, including any required COLA, is projected at the full estimated cost. Appropriated entitlements are also fully funded and advanced farm deficiency and land payments are assumed.

2. The Directors assume the expiration of tax laws and direct spending laws (such as entitlements) that are scheduled to expire during the fiscal year in question. The Act specifies that, notwithstanding the general rule, excise taxes deposited into trust funds are not assumed to expire, and CCC crop price supports and contract authority to the transportation funds are not assumed to expire.

3. If a 12-month appropriation for a discretionary program has not been enacted, the Directors must use "prior year appropriations". This would include regular appropriations as modified by enacted supplementals or rescissions and the final sequestration order from the previous year, if any. Although a full-year continuing appropriation is counted, a temporary continuing appropriation is not considered for the purpose of the budget base. The base is then increased using the GNP price deflator and an allowance is made for Federal pay raises. Seventy percent of Federal pay costs are to be similarly inflated and then reduced using a 22 percent absorption rate.

4. In estimating outlays, the Directors do not consider any deferrals reported pursuant to the Impoundment Control Act.

5. Asset sales and loan repayments are not to be counted in the baseline, or as deficit reduction with the exception of those mandated prior to September 1987. Savings resulting from the transfer of outlays or receipts to the next year do not comprise scoreable savings.

6. In choosing economic and technical assumptions for all the data in the initial report, the OMB may use the economic and technical assumptions of the President's July 15 mid-session review. The July 15 report must also contain a preliminary estimate of the excess deficit and net deficit reduction.

7. OMB deviations from CBO estimates of aggregate outlay reductions, total sequesterable resources, and resources to be sequestered of more than $5 million are to be detailed and explained. OMB must also calculate the required outlay reductions using CBO methodologies. OMB is further restricted from using outlay rates one-half of one percent different from the previous year, and Medicare outlay rates one percent different from the fiscal year's current services estimate.

8. The receipts and outlays of the Social Security Trust Fund are counted even though they are off-budget.

BUDGETARY RESOURCES

The required reductions in outlays are not made directly; rather, they are to be achieved by the permanent cancellation of budget authority and other authority to obligate and expend funds—referred to under Public Law 99-177 as sequestration. For defense programs, sequesterable budgetary resources are new budget authority provided for the budget year and unobligated balances of budget authority provided in previous years. For nondefense programs, the sequesterable budgetary resources are new budget authority, new direct loan obligations, new loan guarantee commitments, obligation limitations, and spending authority as defined in section 401(c)(2) of the Congressional Budget Act of 1974 (spending authority not subject to the annual control of the appropriations process). Included in this definition of spending authority are all entitlements, federal payments financed by offsetting collections that are credited to budget accounts, and various permanent appropriations.

Not all budgetary resources are subject to sequestration. The Act creates four different categories of programs.

1. **Completely Exempt Programs.** Other than their Federal administrative costs, the following programs are completely exempt:

Net Interest;

Social Security retirement and disability;

Railroad Retirement Tier I (the Social Security equivalent);

Dual Benefits Payments;

Veterans Compensation and Pensions;

Federal military and civilian disability and retirement COLA's;

State Unemployment Compensation;

Earned Income Tax Credit;

Selected "Low-Income" programs; AFDC, SSI, Food Stamps; Child Nutrition, WIC, and Medicaid;

Federal power administrations: TVA, BPA, WAPA, SWAPA, SEAPA, and APA;

Postal Service Fund (but not the Federal subsidy);

Accounts paying claims against the U.S., including Claims, Judgments, and Relief Acts; Defense Claims; Payments to Copyright Owners; Eastern Indian Land Claims; Vietnam and U.S.S. *Pueblo* POW Claims; and Soldiers and Airmen's Home Claims;

Constitutionally protected salaries: Compensation of the President, and Salaries of Article III Judges;

Non-U.S. funds of three types: Foreign Military Sales Trust Fund; activities from private bequests, donations, or voluntary contributions; and appropriations for D.C. (but not the Federal subsidy);

Payments from one Federal account to another, since these do not constitute Federal outlays (primarily, sequestration of these resources can only occur once);

Veterans Insurance, Rehabilitation and Burial Funds;

Certain payments to Panama;

Payments to U.S. Territories;

Payments under the Compact of Free Association;

Comptroller of the Currency;

Federal Deposit Insurance Corporation;

Federal Home Loan Bank Board;

Federal Savings and Loan Insurance Corporation;

National Credit Union Administration;

Federal Thrift Retirement Board.

2. **Partially protected programs.** These programs are of two types COLA programs and Special Rule programs. The reductions are limited as described below:

COLA programs, also known as Automatic Spending Increases, may have their COLAs reduced or frozen but their benefit base is protected, that is, the COLAs may not become negative. The programs with automatic spending increases subject to sequestration by the Act as amended are the National Wool Act, Special milk program, and Vocational rehabilitation programs.

Special Rule programs may be cut by specified, limited percentages or amounts. This section describes these special rules.

Guaranteed Student Loan Program

The Act requires two changes in the guaranteed student loan (GSL) program to occur automatically under sequestration. First, the statutory factor for calculating the special allowances for lenders will be reduced by 0.40 percentage points in the first year of loan. Second, a student's origination fee will increase by 0.50 percentage points. In both cases, sequestration affects only GSL loans made during the applicable fiscal year, but after the order is issued.

Foster Care and Adoption Assistance Programs

The Act limits the amount available for sequester in the foster care and adoption assistance programs to increases in foster care maintenance payment rates or adoption assistance payment rates taking effect during the current fiscal year.

Medicare

The sequestration reductions in the medicare program are to be achieved by reducing payment amounts for covered services. No changes in co-insurance or deductible obligations are to be made, and covered services are unaffected under a sequestration order. Under such an order, each payment amount would be reduced by a maximum of 2 percent for each year in which there is sequestration, relative to whatever level of payment would otherwise be made under medicare law and regulation. The reduction would be proportionately reduced in any year in which the excess deficit is small enough to permit a smaller reduction.

Veterans' Medical Care and Other Health Programs

The Act limits reductions in budget authority for veterans' medical care, community and migrant health centers, and Indian health services and facilities to 1 percent in fiscal year 1986 and 2 percent in any subsequent fiscal year.

Child Support Enforcement Programs

In the child support enforcement (CSE) program, the Act provides that sequestration of entitlement payments to states, including incentive payments from the assistance payments account, is to be accomplished by reducing the federal matching rates for state administrative expenses.

Unemployment Compensation Programs

The Act provides that the following items are not available for sequester: regular state unemployment benefits, the state share of extended unemployment benefits, benefits paid to former federal employees and former members of the armed services, and loans and advances to the state and federal unemployment accounts. The federal share of extended benefits, federally paid benefits, including benefits paid under the Railroad Unemployment and Sickness Insurance program, and administrative expenses are available for sequester. The Act also provides that states may, without penalty, reduce their share of federal-state extended unemployment benefits if the federal share of benefits is reduced by a sequester order.

Commodity Credit Corporation

The Act requires that payments and loan eligibility under any contract entered into by the Commodity Credit Corporation (CCC) after a sequester order has been issued for a fiscal year be subject to a percentage reduction. The Act requires that reductions for all farm commodities supported by the CCC be made in a uniform manner, including all noncontract programs, projects, and activities within CCC's jurisdiction. The Act further stipulates that outlay reductions in the post-sequester year that are the result of contract adjustments in the sequester year should be credited to the overall outlay reduction required in the sequester year. The actual amount of savings realized in each year will depend upon how the sequester is implemented for the various CCC programs.

Federal pay

The Act provides that rates of pay for civilian employees (and rates of basic pay, basic subsistence allowances, and basic quarter allowances for members of the uniformed services), or any scheduled pay increases, may not be reduced pursuant to a sequestration order. Budgetary resources available for federal pay, however, will be subject to sequestration as part of the reduction of administrative expenses.

Insurance and Guaranteed Loan Programs

These programs may have their new activities subject to sequestration, but costs associated with insurance claims or with loan defaults are exempt. The Act identifies 46 such programs. In general, these programs support themselves through premiums, so that their net Federal cost is near zero.

For credit programs, the governing measures of sequesterable budgetary resources are direct loan obligations and loan guarantee commitments. The Act requires de facto limitations on both types of new credit activity. This was modified by amendment number 4 in Table 4.

Military personnel accounts

The Act gives the President the authority to exempt all or part of the military personnel accounts from sequestration.

The President used this authority in 1986 and again in the 1988 reports.

3. **Prior-year outlays from otherwise nonexempt programs.** Although these programs are subject to across-the-board sequestration, their prior-year outlays generally are not part of the calculations. Just about $100 billion in defense outlays, and a nearly identical amount in nondefense outlays, are thus excluded from the sequestration calculations. However, new funds for the programs in question are completely available for sequestration.

Specifically, for nondefense programs the Act removes from the calculations all outlays resulting from budgetary resources that were provided in prior fiscal years. Only new budgetary resources are sequesterable, and only the resulting "new" outlays are included in the calculations.

Existing contracts and obligated balances in nondefense and defense programs are exempt from sequestration.

4. **Offsetting receipts.** These receipts are nontax income of the U.S. deposited in the Treasury's General Fund, and are accounted as "negative spending." An example is the income generated by Outer Continental Shelf Rents and Royalties. The Act exempts such income from sequestration calculations, since sequestration is intended to cut spending, not to increase user fees or speed up auction schedules.

ILLUSTRATIVE 1989 CALCULATIONS

1. Budget baseline

Table 2 provides further detail on the OMB and CBO baseline outlay estimates for 1989. About $185 billion of estimated 1989 outlays for defense programs, representing about 63 percent of total defense spending, are associated with budgetary resources subject to an across-the-board percentage reduction. If military personnel accounts are exempted by the President, approximately $110 billion of defense outlays are subject to sequestration (see memorandum at bottom of table).

According to OMB estimates, about $210 billion, or one-fourth of estimated outlays for nondefense programs, is associated with sequesterable budgetary resources. Only $1 billion in outlays are for programs with automatic spending increases. Another $105 billion is outlays is associated with certain special rule programs, of which the largest is medicare. The Act also limits the extent of spending reductions for these programs. Only slightly more than $105 billion in estimated 1989 nondefense outlays—about 13 percent of total—are associated with budgetary resources subject to an across-the-board percentage reduction. Over $603 billion, almost three-fourths of total estimated outlays for nondefense programs, are exempt from sequestration by the Act. As shown in table 2, the major exempt program outlays are mostly for social security and net interest. The remaining portion of nondefense outlays, about $200 billion, results from budgetary resources provided in previous years or from prior legal obligations.

TABLE 2.—OMB AND CBO COMPOSITION OF BASELINE OUTLAYS FOR 1989

[In billions of dollars]

	OMB		CBO	
	Estimate	Percent of total	Estimate	Percent of total
Defense: [1]				
Subject to across-the-board reduction	182.9	16.5	186.3	16.5
Exempt from sequestration [2]	110.8	10.0	108.5	9.6
Subtotal, defense programs	293.7	26.5	294.9	26.1
Nondefense programs:				
Subject to sequestration:				
Certain programs with automatic spending increases [3]	1.3	0.1	1.6	0.1
Programs subject to special rules [4]	104.6	9.4	111.4	9.9
Subject to across-the-board reduction [5]	104.7	9.5	103.0	9.1
Subtotal, subject to sequestration	210.5	19.0	216.0	19.1
Exempt from sequestration:				
Social security	232.6	21.0	232.7	20.6
Federal retirement, disability, and workers compensation	61.1	5.5	61.0	5.4
Earned income tax credit	3.9	0.4	4.1	0.4
Low-income programs [6]	74.4	6.7	78.6	7.0
Veterans compensation and pensions	14.9	1.3	14.8	1.3
State unemployment benefits	14.4	1.3	15.7	1.4
Offsetting receipts	−61.7	−5.6	−58.4	−5.2
Net interest	152.1	13.7	165.9	14.7
Other [2]	111.4	10.1	103.8	9.2
Subtotal, exempt from sequestration	603.1	54.5	618.2	54.8
Subtotal, nondefense programs	813.6	73.5	834.2	73.9
Total	1,107.4	100.0	1,129.0	100.0
Memorandum:				
Defense with all military personnel accounts exempt:				
Subject to across-the-board reduction	107.4	9.7	110.4	9.8
Exempt from sequestration	186.3	16.8	184.4	16.3

[1] Excludes Federal Emergency Management Agency accounts.

[2] Outlays from obligated balances.

[3] National Wool Act, special milk, and vocational rehabilitation programs.

[4] Guaranteed student loans, foster care and adoption assistance, Medicare, veterans medical care, and other health programs.

[5] Excludes 1990 outlays for the Commodity Credit Corporation.

[6] Family support payments, child nutrition, Medicaid, food stamps, SSI, WIC, CSFP, and nutrition assistance to Puerto Rico.

2. Sequestration calculations

The Act establishes the following steps for the sequestration calculations. First, the deficit excess is calculated by subtracting the maximum amount from the estimated deficit in the budget base. One-half is assigned to defense programs (budget accounts in function 050) and the other half to nondefense programs.

Second, the total amount of outlay savings from eliminating automatic spending increases is calculated. All savings from eliminating automatic spending increases in three specific programs—the National Wool Act, the special milk program, and vocational rehabilitation—are applied to the required reduction in outlays for nondefense programs.

Third, the amount of outlay savings to be obtained by applying four special rules is calculated. These special rules are for guaranteed student loans, foster care and adoption assistance, medicare, and certain health programs, and are described in a later section of this report. The estimated savings from these four special rules are applied toward the required spending reductions in nondefense programs.

The remaining reductions in defense programs and nondefense programs must be taken on a uniform percentage basis, computed separately for each category. The uniform reduction percentages are computed from outlay estimates. The remaining outlay savings to be achieved in defense and nondefense spending are divided by the estimated outlays associated with sequesterable budgetary resources in each category. These uniform percentages are then applied to all of the remaining sequesterable budgetary resources (budget authority, credit authority, and other spending authority) for defense and nondefense programs.

In the event a short-term continuing resolution is in effect when the final sequestration order is issued, the amended law establishes a slightly different process for sequestration. A pro rata share of the dollar amount is applied to the continuing resolution then in place, and any subsequent short term appropriations. The total pro rata shares apply toward the total sequester. If the full year bill appropriates a level lower than the account's baseline, credit is given for the sequestrations below baseline.

For each $10 billion change in the excess deficit, the reduction percentage for defense programs would change by about 2.7 percentage points, and for nondefense programs by about 4.4 percentage points.

Estimates of across-the-board reductions at this time (March, 1988) are merely previews. Ultimately, any cutbacks will depend on estimates made by the Office of Management and Budget in August and October. By then, of course, the economic outlook may have changed.

In February, under the specifications set forth in the Act, OMB estimated a deficit for 1989 of $142.7 billion. Since the estimated deficit exceeds $136 billion by less than $10 billion, a sequester would not be triggered.

Also in February, however, CBO estimated the 1989 deficit at $176 billion, $40 billion above the Act's target. The maximum sequestration allowed under the law is $36 billion. Cutting $36 billion wholly through sequestration would require reductions of approximately 16.3 percent in defense programs (assuming all military personnel are exempted) and 14.2 percent in nondefense, nonexempt programs. Table 3 illustrates these calculations for fiscal year 1989 under CBO assumptions.

TABLE 3.—CBO CALCULATIONS OF AN ILLUSTRATIVE SEQUESTRATION FOR 1989

[Outlays in billions of dollars]

Sequestration items	Defense programs	Nondefense programs
Total required reductions	18.0	18.0
Savings from eliminating automatic spending increases		(1)
Savings under special rules		1.7
Remaining reduction required	18.0	16.3
Sequestration outlay base	[2] 186.3	[3] 114.4
Uniform reduction percentage	[4] 9.7	14.2
Required spending authority reduction [5]	33.9	33.3

[1] Less than $50 million.

[2] Includes $75.9 billion in outlays for military personnel.

[3] Includes $11.5 billion in estimated 1990 outlays for the Commodity Credit Corporation that can be affected by a 1989 sequestration.

[4] The reduction would be 16.3 percent if military personnel were exempted from sequestration.

[5] Budget authority, obligation limitations, entitlement authority, and other section 401(e)(2) spending authority in the case of nondefense programs and budget authority and unobligated balances in the case of defense programs associated with the outlay reductions of $18.0 billion in defense programs and $16.3 billion in nondefense programs.

Source: Congressional Budget Office.

FURTHER DESCRIPTION OF THE ACT

Budgetary resources further defined

Budgetary resources allow an agency's budget officer to incur financial obligations. Budgetary resources are the legal authority to sign binding service or procurement contracts, to hire personnel, to make grants, or to commit to any other payment required by law.

Budgetary resources are most commonly measured by new budget authority (usually called "BA"). Most new budget authority is provided in annual appropriation acts. The remainder is provided automatically by substantive law, and is called "permanent budget authority" or "permanent appropriations." But, for the purposes of the Act, budgetary resources go beyond new budget authority.

The Act treats defense programs differently from nondefense programs. For defense, the sequesterable budgetary resources are (1) new budget authority, and (2) unobligated balances of prior budget authority.

For nondefense programs, there are five different types of budgetary resources that are subject to sequestration:

(1) new *budget authority;*

(2) gross levels of new *direct loan* obligations;

(3) other *obligation limitations* (generally, limitations on programmatic or administrative obligations from trust or revolving funds);

(4) "spending authority defined in Sec. 410(c)(2) of the Congressional Budget Act" (commonly known as "direct spending" or "*backdoor spending*"); and

(5) new loan guarantee commitments.

Loan guarantee commitments are not considered to require budget authority or produce outlays, since they merely guarantee that one private party, a borrower, will repay a loan to another private party, a lender. However, if the borrower defaults the U.S. must bear the costs. Default payments are Federal outlays, but are exempt from sequestration.

Sequestration of loan guarantees reduces the government's contingent liability. In the long run, this would lead to lower default payments. Since most loan guarantee programs are self-financed (up-front permiums cover expected defaults), sequestration will have the shortrun effect of slightly reducing Federal income from premiums.

Programs with two types of budgetary resource are numerous. For example, the Federal-aid highway program receives new budget authority (in the form of contract authority) and has an obligation limitation. Many direct loan programs receive new budget authority (in the form of borrowing authority) though they are controlled by loan limitations. Some entitlements (a common form of backdoor spending) receive annual appropriations of budget authority in appropriation bills.

In general, if a program is controlled by both definite budget authority and another budgetary resource, then both budgetary resources are reduced through sequestration. If a program receives indefinite budget authority ("such amounts as may be necessary") but is controlled by a different budgetary resource, such as a direct loan limitation, then only the latter resource is directly reduced through sequestration. The amount of indefinite budget authority will automatically be reduced as a consequence, though not necessarily by the same amount or percentage.

Program, Project, or Activity (PPA). The Act requires that, in implementing sequestration, the President cut each "program, project, or activity" (PPA) within a budget account by the same percentage. There are single-purpose accounts as well as multi-purpose accounts. For example, the Budget Appendix lists eight "activities" within the Training and Employment Services account: Block Grant to States: Summer Youth Employment; Dislocated Worker Assistance; Native Americans; Migrant and Seasonal Farmworkers: Job Corps: Veterans Employment: and National Activities. The intent is that sequestration reduce each PPA by the same percentage.

The term "program, project, and activity" does not have a statutory definition. Instead, the Act specifies that, for accounts funded through annual appropriations, the term is to be defined each year in appropriation bills or in their accompanying reports and other related documentation. For accounts not funded by annual appropriations, PPAs are defined by the budget authority listing in the Budget Appendix.

For both defense and nondefense accounts, the amounts cut from each PPA are not specified until the Presidential order and accompanying message are issued.

In applying the percentage reduction to each PPA, the President is not given new authority to alter the relative priorities in the Federal budget that are established by law and no person who is or becomes eligible for benefits under any provision of law shall be denied eligibility as a result of sequestration. For example, this meant that the reduction in low-income home energy assistance was not uniform across states because authorizing law for this program contained certain hold-harmless provisions.

FEDERAL ADMINISTRATIVE COSTS

The Act provides that Federal administrative expenses incurred in connection with any program, activity, or account shall be subject to reduction under a sequester order. Any exemption, exception, limitation, or special rule is not intended to include these Federal administrative or operating expenses unless it does so by specific reference.

Under this provision, administrative or operating expenses of all the departments and agencies of the Federal government, including independent agencies, would be subject to reduction unless specifically exempted. This provision includes programs and agencies that are self-financing and that do not receive appropriations.

The term administrative or operating expenses is intended to include obligations for items such as personnel compensation, travel, transportation, communication, equipment, supplies, materials, and other services. It is not the intent of the conferees to include payments, loans, or other benefits resulting from prior legal obligations under the term administrative or operating expenses.

For purposes of this section, payments made by the Federal government to reimburse or match administrative costs incurred by State or local governments, such as the Federal matching payments for State AFDC, costs for State disability determination units and Medicaid administrative expenses shall not be considered administrative expenses.

CONGRESSIONAL RESPONSE

In the Senate, a procedure exists to allow the Senate Budget Committee to affirm, in whole or in part, the sequestration order issued after enactment of a joint sequestration resolution, and provide for a congressional response using a conciliation-type process involving instructions to committees. The Senate Budget Committee would have the authority to include in a reconciliation bill pursuant to those procedures actual legislative language fulfilling the instruction to a committee which completely fails to comply.

These procedures are necessary to enable the Senate to respond quickly to an order by limiting debate and amendments which would not be limited under normal Senate procedures. Since the House has the ability to take legislation through the Committee on Rules, which can limit debate and amendments, there are not specific procedures for responding to an order.

MODIFICATION OF A PRESIDENTIAL ORDER

In the Reaffirmation Act, Congress provided itself with an expedited procedure to modify or cancel the most recent sequestration order.

Within 10 calendar days afer the OMB director issues his final report, it is the exclusive right of either majority leader to introduce a joint resolution (thereby requiring a Presidential signature) that directs the President to alter or cancel the sequestration.

No other joint resolution may be considered under privileged and expedited procedures for up to eight days after introduction. The joint resolution is not referred to committee. Four hours of debate are allowed in the House and ten in the Senate.

JUDICIAL REVIEW

The Act authorizes expedited judicial review of constitutional questions raised by a Member of Congress or any other adversely affected person. Legal action may be brought by a Member of Congress in the United States District Court for the District of Columbia on the grounds that any sequestration order that might be issued violates the Constitution or that the Presidential sequestration order does not comply with requirements of the Act. The measure specifically provides that such an action will be heard by a three-judge panel of the U.S. District Court for the District of Columbia, and authorizes an immediate appeal to the U.S. Supreme Court.

If a court of competent jurisdiction finally determines that an order issued by the President under the Act for any fiscal year does not comply with the sequestration procedures, the President must, within 20 days after such a determination is made, revise the order in accordance with the judicial determination. If the Presidential order does not comply with the sequestration procedures on the claim or defense that the constitutional powers of the President prevent such sequestration and such claim or defense is finally determined by the United States Supreme Court to be valid, then the entire order for such fiscal year is null and void.

An order by a court granting declaratory or injunctive relief from a Presidential sequestration order, including relief permitting or requiring expenditure of sequestered funds, does not take effect during the pendency of the action or an appeal until the court has entered its final order disposing of the action.

AMENDMENTS TO THE CONGRESSIONAL BUDGET ACT

In addition to establishing a new procedure, "sequestration," as part of the Executive and Congressional budget processes, the Act also substantially amended the existing budget process. Most of the reforms codify congressional budget practices that have evolved since the original Congressional Budget Act was adopted in 1974. However, some are designed to enforce the maximum deficit amounts set forth in the Budget Act.

The Act requries the President to submit a budget which does not exceed the maximum deficit amount for the applicable fiscal year. Further, congressional budget resolutions must also be within the maximum deficit amount of the applicable fiscal year. (This prohibition is enforced by points of order in the House and Senate.)

As noted earlier, the Act provides that a budget resolution cannot contain a deficit level in excess of the MDA for the applicable fiscal years. This prohibition applies to the committee-reported budget resolution, any amendments thereto, or conference report thereon. In the House, three-fifths of Members present and voting are required to waive this point of order against a *conference report* on a budget resolution. This is the only super-majority waiver requirement created by the Act applicable in the House of Representatives.

The revenues and disbursements of the Social Security program are included in the calculation of the deficit for purposes of the congressional budget resolution, the President's budget, and the excess deficit. For all other purposes Social Security is considered off-budget. A new point of order is established which prohibits any changes to the Social Security program to be included in a reconciliation bill pursuant to a budget resolution (this prohibition also applies to a Senate-originated response to sequestration.)

The Budget Act is amended to establish spending controls at the subcommittee or program level. Legislation is subject to a point of order if it exceeds the appropriate committee's section 302(b) subdivision of new discretionary budget authority, new entitlement authority or credit authority. (In the Senate the point of order is based upon budget authority and outlays.) Under current law this subdivision is not binding.

Other amendments to the Budget Act codify existing congressional practices. For example, the Budget Act is amended to require adoption of only one annual budget resolution (although it may be revised at any time). The content of the resolution is expanded to include advisory budgetary levels for the two succeeding fiscal years, and reconciliation instructions for three fiscal years. Section 302(a) of the Budget Act is amended to reflect how the House and Senate Budget Committees technically allocate the spending authority in the budget resolution to the committees of jurisdiction. In the House, a committee is "held harmless" from certain points of order if it is within its section 302(a) total allocation of new discretionary budget authority and new entitlement authority.

The scope of the budget process is expanded to establish binding levels on credit authority, to require new credit authority to be subject to the appropriations process, and to define new types of "backdoor" spending authority.

Finally, the timetable for the budget process is accelerated. In addition to the timetable below, House rules are amended to require early organization of the House.

CONGRESSIONAL BUDGET PROCESS TIMETABLE

On or before:	
First Monday after January 3	President submits his budget.
February 15	Congressional Budget Office submits report to Budget Committees.

CONGRESSIONAL BUDGET PROCESS TIMETABLE—Continued

February 25	Committees submit views and estimates to Budget Committee.
April 1	Senate Budget Committee reports concurrent resolution on the budget.
April 15	Congress completes action on concurrent resolution on the budget.
May 15	Annual appropriation bills may be considered in the House.
June 10	House Appropriations Committee reports last annual appropriation bill.
June 30	Congress completes action on reconciliation legislation.
October 1	Fiscal year begins.

LEGISLATIVE HISTORY OF THE BALANCED BUDGET AND EMERGENCY DEFICIT CONTROL ACT OF 1985

The triggering process in the original Gramm-Rudman-Hollings law, enacted in December 1985, was declared unconstitutional by the Supreme Court the following summer. The role of the Comptroller General as the implementing agent of the sequester was found to violate the separation of powers. As an agent under the employment and control of the Congress, the GAO cannot constitutionally carry out executive duties.

The Balanced Budget and Emergency Deficit Control Act of 1985 differed from current law in three areas—the role of GAO as executor of the sequestration, the uninflated baseline and the maximum deficit amounts. The only other significant change to Gramm-Rudman occurred in the fiscal year 1987 reconciliation bill. Federal military and civilian retirement and disability cost of living allowances were exempted from any reductions under the law. Other legislation since 1985 has made other exemptions of smaller budget accounts. A list of these exemptions are in table 4.

TABLE 4.—LISTING OF EXEMPTIONS TO SEQUESTRATION PROCEDURES

1. Panama Canal Commission Authorization Act, Fiscal Year 1987 (P.L. 99–368, H.R. 4409, August 1, 1986).

   Section 6 exempts the Commission from sequestration under the 1985 Balanced Budget Act to the extent that such reduction would result in payments to the Republic of Panama.

2. Insular Areas Regulation Act (P.L. 99–396, H.R. 2478, August 27, 1986).

   Section 19 requires that Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands be paid the full amounts required under the laws establishing their relationship with the United States, notwithstanding the 1985 Balanced Budget Act.

3. Omnibus Budget Reconciliation Act of 1986 (P.L. 99–509, H.R. 5300, October 21, 1986).

   Section 7001 exempts cost-of-living (COLA) increases of all Federal Government civilian and military disability and retirement programs from sequestration under the

1985 Balanced Budget Act (covering calendar years 1987 through 1991) so that they are treated under the Act in the same manner as Social Security.

Section 7002 exempts the "Dual benefits payments account" (60–0111–0–1–601–that part of railroad retiree benefits that are Federally funded through regular appropriations acts—from sequestration under the 1985 Balanced Budget Act so that the basic program benefits are treated under the Act in the same manner as other Federal retirement programs.

4. Omnibus Veterans' Benefits Improvement and Health Care Authorization Act of 1986 (P.L. 99–576, H.R. 5299, October 28, 1986).

Title VI exempts various veterans' benefit programs from sequestration under the 1985 Balanced Budget Act, and modifies procedures for the preparation of OMB/CBO joint reports on sequestration and the implementation of sequester orders with regard to veterans' programs.

5. Palau Compact of Free Association Act (P.L. 99–658, H.J. Res. 626, November 14, 1986).

Section 104(f) provides that appropriated amounts required to be paid under the Compact of Free Association Act of 1985 or the Palau Compact of Free Association Act shail not be reduced under the 1985 Balanced Budget Act or other laws.

6. Competitive Equality Banking Act (P.L. 100–86, H.R. 27, (August 10, 1987).

Section 506 exempts the Comptroller of the Currency. Federal Deposit Insurance Corporation, Federal Home Loan Bank Board, Federal Savings and Loan Insurance Corporation, and the National Credit Union Administration from sequestration of administrative expenses.

7. The Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987 (P.L. 100–19 H.J. Res. 324, September 29, 1987).

Section 104 exempts the Federal Retirement Thrift Investment Board from sequestration of administration expenses, prohibits sequestration of Washington Metropolitan Area Transit Authority interest payments, and clarifies the treatment of other accounts.

8. The Omnibus Budget Reconciliation Act of 1987 (P.L. 100–203, H.R. 3545, December 22, 1987).

Section 8003(f) clarifies the treatment of FHA fund insurance program in construction of baseline spending estimates.

Under the original law and the current Reaffirmation Act, two sequesters have resulted. In 1986, a small sequestration of $11.7 billion occurred. The Court, while invalidating the automatic trigger of the Act, permitted the sequester to stand. In fiscal year 1987, the Congress operated under the "fallback" procedure using the Temporary Joint Committee on the Budget described earlier. The deficit was reduced prior to the end of the year and sequestration was avoided. In fiscal year 1988, a partial year sequester was in effect during the short term continuing resolution until December 22, 1987. At that time, the President signed the economic summit agreement embodied in the 1987 reconciliation bill and continuing resolution, voiding the $23 billion sequester. Table 5 and 6 show the baseline levels and sequestration for fiscal 1986. Table 7 illustrates the same data for fiscal year 1988.

TABLE 5.—BASE LEVEL OUTLAY ESTIMATES FOR 1986

[In billions of dollars]

Category	OMB estimates	CBO estimates	OMB/CBO average	GAO
Defense Programs: [1]				
Subject to across-the-board reduction	106.2	112.4	109.3	110.3
Other [2]	164.7	162.1	163.4	....
Subtotal defense programs	270.9	274.6	272.8	....
Nondefense Programs:				
Programs with automatic spending increases [3]	48.9	48.4	48.6	....
Certain special rule programs [4]	87.0	87.1	87.1	....
Subject to across-the-board reduction	104.3	106.1	105.2	105.6
Major exempt programs:				
Social security and railroad retirement tier 1	202.6	202.0	202.3	....
Net interest	137.9	136.9	137.4	....
Earned income tax credit	1.3	1.3	1.3	....
Low-income programs [5]	60.9	61.1	61.0	....
Veterans compensation and pensions	14.3	14.3	14.3	....
State unemployment benefits	18.2	18.1	18.2	....
Offsetting receipts	−50.2	−50.5	−50.4	....
Other [6]	98.8	98.7	98.8	....
Subtotal, nondefense programs	724.0	723.4	723.7	....
Total	994.9	998.0	996.5	....

[1] Budget function 050 excluding FEMA programs.

[2] Outlays from obligated balances and the portion of military personnel accounts exempted by the President for 1986.

[3] Primarily federal employee retirement and disability programs.

[4] Guaranteed student loans, foster care and adoption assistance, medicare, veterans medical care, community health, migrant health, and Indian health.

[5] AFDC, child nutrition, medicaid, food stamps, SSI, and WIC.

[6] Outlays from prior-year appropriations, certain prior legal obligations, and small exempt programs.

Source: Congressional Budget Office, Office of Management and Budget, and General Accounting Office.

TABLE 6.—SEQUESTRATION CALCULATIONS FOR 1986

[Outlays in millions of dollars]

Category	OMB	CBO	OMB/CBO average	GAO
Defense programs:				
Total required reductions	5,850	5,850	5,850	5,850
Estimated savings from automatic spending increases:				
Indexed retirement programs [1]	496	497	497	497

TABLE 6.—SEQUESTRATION CALCULATIONS FOR 1986—Continued

[Outlays in millions of dollars]

Category	OMB	CBO	OMB/ CBO average	GAO
Amount remaining to be obtained from uniform percentage reductions of budget resources	5,354	5,353	5,353	5,353
Estimated outlays associated with sequesterable budget resources	106,225	112,446	109,335	110,300
Uniform reduction percentage	5.0	4.8	4.9	4.9
Nondefense programs:				
Total required reductions	5,850	5,850	5,850	5,850
Estimated savings from automatic spending increases:				
Indexed retirement programs	496	497	497	497
Other indexed programs	45	45	45	45
Estimated savings from the application of special rules:				
Guaranteed student loans	10	10	10	10
Foster care and adoption assistance	5	5	5	5
Medicare	300	300	300	300
Other health programs	82	83	82	82
Amount remaining to be obtained from uniform percentage reductions of budget resources	4,912	4,911	4,912	4,912
Estimated outlays associated with sequesterable budget resources [2]	114,444	115,080	114,762	115,200
Uniform reduction percentage	4.3	4.3	4.3	4.3

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[1] These retirement programs are not included in the national defense function of the budget; most are included in the income security function.

[2] Includes estimated 1987 outlays for the Commodity Credit Corporation (CCC) that can be affected by a 1986 sequester (see discussion of special rule for the CCC). The OMB estimate is $10,095 million, the CBO estimate is $8,940 million, and the average is $9,518 million.

Sources: Congressional Budget Office, Office of Management and Budget and General Accounting Office.

TABLE 7.—SUMMARY OF SEQUESTRATION AMOUNTS FOR FY88

[Amounts in billions of dollars except uniform reduction percentage]

Estimate or calculation	CBO (11-16-87)	OMB (11-20-87)
Total revenues	897.0	903.0
Total outlays	1,076.9	1,067.0
Deficit	179.9	164.0
Deficit target	144.0	144.0
Deficit excess	35.9	20.0
Net deficit reduction since January 1	0.0	0.0
Required outlay reductions (set by Act)	23.0	23.0

TABLE 7.—SUMMARY OF SEQUESTRATION AMOUNTS FOR FY88—Continued

[Amounts in billions of dollars except uniform reduction percentage]

Estimate or calculation	CBO (11–16–87)	OMB (11–20–87)
Outlay reductions in defense programs	11.5	11.5
Sequestration outlay base for uniform cuts	110.5	109.2
Uniform reduction percentage	(10.4)	(10.5)
Outlay reduction in nondefense programs	11.5	11.5
Reductions in indexed programs and programs covered by special rules	1.6	1.5
Remaining outlay reductions	9.9	10.0
Sequestration outlay base for uniform cuts	113.5	117.6
Uniform reduction percentage	(8.7)	(8.5)

THE AUTOMATIC TRIGGERING OF SEQUESTRATION

In the original Act, the final Presidential sequestration orders were automatic and based on the report of the Comptroller General of the GAO. In determining the automatic reductions, the GAO was to give "due regard" to the joint report of the CBO and OMB directors.

THE BUDGET BASELINE

The original budget baseline was nearly $10 billion lower than the amended version. No discretionary inflation was added to the defense and non-defense appropriated accounts. All federal pay raises were assumed to be the amounts recommended by the President in either his budget or August request. Except in the entitlement programs, cuts made from this base were "real" reductions in spending versus elimination of inflationary increases.

When CBO and OMB made their joint report, the differences between them were to be averaged. Varying interpretations of the law led to significant discrepancies in the baseline estimates of spending, revenues, and the deficit excess. Along with differing economic projections, the assumptions on Medicare payment rates, appropriated entitlements, advanced farm deficiency payments, spendout rates and budgeting of federal pay raises resulted in differences of nearly $30 billion between the directors. The Reaffirmation Act, while giving OMB the final "say" in calculating sequestration levels clarified and tightened the procedure.

BUDGETARY RESOURCES

The budgetary resources that are available for sequestration have changed from the original law to the present. Through various laws, many other programs have been exempted from sequestration. Some of these exemptions were purely for technical reasons while others were political decisions of the Congress. The largest changes were the removal of all cost-of-living adjustments for federal and military disabled and retired. Exemption of nearly $50 billion from the baseline effectively eliminated the section of the law on automatic increases. In January 1986, the COLAs were suspended and half of the savings were credited to the defense and half to the non-defense percentage reductions as required.

Previously, sequestration of defense contracts and obligated balances were permitted at the President's discretion, but only if the cancellation would not result in a net cost to the Government or violate a contractual agreement. No contracts were terminated or modified in the 1986 sequestration, and obligated balances and contracts have been removed as budgetary resources in the Reaffirmation Act.

In the 1986 sequestration, the President was permitted, and chose to take, a one time opportunity to make adjustments in parts of the defense cutback. The President could reduce or exempt any defense program, project or activity provided that each budget account was reduced by the full percentage. PPAs within an account could be reduced up to two times the required percentages to make up for lower cuts elsewhere. The President was not allowed to fund an activity more than its baseline level, close military bases, terminate any PPA, or reduce items of Congressional interest by a percentage larger than sequestration.

CHANGES TO THE BUDGET ACT

Until the Balanced Budget Act, waivers of the points of order of the Budget Act required a simple majority. With Gramm-Rudman, the Senate required a three-fifths vote of all Members (60) to waive the rules. It was still possible at the time to waive a point of order by a simple majority through a vote to overturn the ruling of the Chair. The Reaffirmation Act removed the ability of the Senate to get around the simple majority waiver.

The Gramm-Rudman law mandated additional waivers of the Budget Act regarding the MDA in budget resolutions and reconciliation bills. It also expedited the timetable. Most of the changes are explained in the previous section on the workings of the Budget Act. The only significant change made to the timetable by the Reaffirmation Act was removal of the restriction permitting adjournment for the Fourth of July recess without House passage of a reconciliation bill—a requirement that was never enforced.

APPENDIX M

EXCERPTS FROM THE CONGRESSIONAL BUDGET AND IMPOUNDMENT CONTROL ACT OF 1974, AS AMENDED BY THE BALANCED BUDGET AND EMERGENCY DEFICIT CONTROL ACT OF 1985 (PUBLIC LAW 99-177)

* * * * * * *

TITLE III—CONGRESSIONAL BUDGET PROCESS

TIMETABLE

SEC. 300. The timetable with respect to the congressional budget process for any fiscal year is as follows:

On or before:	Action to be completed:
First Monday after January 3	President submits his budget.
February 15	Congressional Budget Office submits report to Budget Committees.
February 25	Committees submit views and estimates to Budget Committees.
April 1	Senate Budget Committee reports concurrent resolution on the budget.
April 15	Congress completes action on concurrent resolution on the budget.
May 15	Annual appropriation bills may be considered in the House.
June 10	House Appropriations Committee reports last annual appropriation bill.
June 15	Congress completes action on reconciliation legislation.
June 30	House completes action on annual appropriation bills.
October 1	Fiscal year begins.

ANNUAL ADOPTION OF CONCURRENT RESOLUTION ON THE BUDGET

SEC. 301. (a) CONTENT OF CONCURRENT RESOLUTION ON THE BUDGET.—On or before April 15 of each year, the Congress shall complete action on a concurrent resolution on the budget for the fiscal year beginning on October 1 of such year. The concurrent resolution shall set forth appropriate levels for the fiscal year beginning on October 1 of such year, and planning levels for each of the two ensuing fiscal years, for the following—

(1) totals of new budget authority, budget outlays, direct loan obligations, and primary loan guarantee commitments;

(2) total Federal revenues and the amount, if any, by which the aggregate level of Federal revenues should be increased or decreased by bills and resolutions to be reported by the appropriation committees;

(3) the surplus or deficit in the budget;

(4) new budget authority, budget outlays, direct loan obligations, and primary loan guarantee commitments for each

major functional category, based on allocations of the total levels set forth pursuant to paragraph (1); and

(5) the public debt.

(b) ADDITIONAL MATTERS IN CONCURRENT RESOLUTION.—The concurrent resolution on the budget may—

(1) set forth, if required by subsection (f), the calendar year in which, in the opinion of the Congress, the goals for reducing unemployment set forth in section 4(b) of the Employment Act of 1946 should be achieved;

(2) include reconciliation directives described in section 310;

(3) require a procedure under which all or certain bills or resolutions providing new budget authority or new entitlement authority for such fiscal year shall not be enrolled until the Congress has completed action on any reconciliation bill or reconciliation resolution or both required by such concurrent resolution to be reported in accordance with section 310(b); and

(4) set forth such other matters, and require such other procedures, relating to the budget, as may be appropriate to carry out the purposes of this Act.

(c) CONSIDERATION OF PROCEDURES OR MATTERS WHICH HAVE THE EFFECT OF CHANGING ANY RULE OF THE HOUSE OF REPRESENTATIVES.—If the Committee on the Budget of the House of Representatives reports any concurrent resolution on the budget which includes any procedure or matter which has the effect of changing any rule of the House of Representatives, such concurrent resolution shall then be referred to the Committee on Rules with instructions to report it within five calendar days (not counting any day on which the House is not in session). The Committee on Rules shall have jurisdiction to report any concurrent resolution referred to it under this paragraph with an amendment or amendments changing or striking out any such procedure or matter.

(d) VIEWS AND ESTIMATES OF OTHER COMMITTEES.—On or before February 25 of each year, each committee of the House of Representatives having legislative jurisdiction shall submit to the Committee on the Budget of the House and each committee of the Senate having legislative jurisdiction shall submit to the Committee on the Budget of the Senate its views and estimates (as determined by the committee making such submission) with respect to all matters set forth in subsections (a) and (b) which relate to matters within the jurisdiction or functions of such committee. The Joint Economic Committee shall submit to the Committee on the Budget of both Houses its recommendations as to the fiscal policy appropriate to the goals of the Employment Act of 1946. Any other committee of the House of Representatives or the Senate may submit to the Committee on the Budget of its House, and any joint committee of the Congress may submit to the Committee on the Budget of both Houses, its views and estimates with respect to all matters set forth in subsections (a) and (b) which relate to matters within its jurisdiction or functions.

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(g) ECONOMIC ASSUMPTIONS.—

(1) It shall not be in order in the Senate to consider any concurrent resolution on the budget for a fiscal year, or any

amendment thereto, or any conference report thereon, that sets forth amounts and levels that are determined on the basis of more than one set of economic and technical assumptions.

(2) The joint explanatory statement accompanying a conference report on a concurrent resolution on the budget shall set forth the common economic assumptions upon which such joint statement and conference report are based, or upon which any amendment contained in the joint explanatory statement to be proposed by the conferees in the case of technical disagreement, is based.

(3) Subject to periodic reestimation based on changed economic conditions or technical estimates, determinations under titles III and IV of the Congressional Budget Act of 1974 shall be based upon such common economic and technical assumptions.

(h) BUDGET COMMITTEES CONSULTATION WITH COMMITTEES.—The Committee on the Budget of the House of Representatives shall consult with the committees of its House having legislative jurisdiction during the preparation, consideration, and enforcement of the concurrent resolution on the budget with respect to all matters which relate to the jurisdiction or functions of such committees.

(i) MAXIMUM DEFICIT AMOUNT MAY NOT BE EXCEEDED.[1]

(1)(A) Except as provided in paragraph (2), it shall not be in order in either the House of Representatives or the Senate to consider any concurrent resolution on the budget for a fiscal year under this section, or to consider any amendment to such a concurrent resolution, or to consider a conference report on such a concurrent resolution, if the level of total budget outlays for such fiscal year that is set forth in such concurrent resolution or conference report exceeds the recommended level of Federal revenues set forth for that year by an amount that is greater than the maximum deficit amount for such fiscal year as determined under section 3(7), or if the adoption of such amendment would result in a level of total budget outlays for that fiscal year which exceeds the recommended level of Federal revenues for that fiscal year, by an amount that is greater than the maximum deficit amount for such fiscal year as determined under section 3(7).

(B) In the House of Representatives the point of order established under subparagraph (A) with respect to the consideration of a conference report or with respect to the consideration of a motion to concur, with or without an amendment or amendments, in a Senate amendment, the stage of disagreement having been reached, may be waived only by a vote of three-fifths of the Members present and voting, a quorum being present.

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[1] Section 301(i) expires on September 30, 1993: P.L. 99-177, section 275(b)(2)(B), as amended by P.L. 100-119. The point of order under this section may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn; P.L. 99-177, section 271(b). In the Senate, whenever such a three-fifths vote is required to waive a point of order under this Act, such a three-fifths vote is also required to sustain an appeal of the ruling of the Chair on such point of order; P.L. 99-177, section 271, as amended by P.L. 100-119, section 210(a).

(2)(A) Paragraph (1) of this subsection shall not apply if a declaration of war by the Congress is in effect.

(B) Paragraph (1) shall not apply to the consideration of any concurrent resolution on the budget for fiscal year 1988 or fiscal year 1989, or amendment thereto or conference report thereon, if such concurrent resolution or conference report provides, or in the case of an amendment if the concurrent resolution as changed by the adoption of such amendment would provide for deficit reduction from a budget baseline estimate as specified in section 251(a)(6) of the Balanced Budget and Emergency Deficit Control Act of 1985 for such fiscal year (based on laws in effect on January 1 of the calendar year during which the fiscal year begins) equal to or greater than the maximum amount of unachieved deficit reduction for such fiscal year as specified in section 251(a)(3)(A) of such Act.

(C) For purposes of the application of subparagraph (B), the amount of deficit reduction for a fiscal year provided for in a concurrent resolution, or amendment thereto or conference report thereon, shall be determined on the basis of estimates made by the Committee on the Budget of the House of Representatives or of the Senate, as the case may be.

COMMITTEE ALLOCATIONS

SEC. 302. (a) ALLOCATION OF TOTALS.—

(1) For the House of Representatives, the joint explanatory statement accompanying a conference report on a concurrent resolution on the budget shall include an estimated allocation, based upon such concurrent resolution as recommended in such conference report, of the appropriate levels of total budget outlays, total new budget authority, total entitlement authority, and total credit authority among each committee of the House of Representatives which has jurisdiction over laws, bills and resolutions providing such new budget authority, such entitlement authority, or such credit authority. The allocation shall, for each committee, divide new budget authority, entitlement authority, and credit authority between amounts provided or required by law on the date of such conference report (mandatory or uncontrollable amounts), and amounts not so provided or required (discretionary or controllable amounts), and shall make the same division for estimated outlays that would result from such new budget authority.

(2) For the Senate, the joint explanatory statement accompanying a conference report of a concurrent resolution on the budget shall include an estimated allocation, based upon such concurrent resolution as recommended in such conference report, of the appropriate levels of total budget outlays, total new budget authority and new credit authority among each committee of the House of Representatives and the Senate which has jurisdiction over bills and resolutions providing such new budget authority.

(b) REPORTS BY COMMITTEES.—As soon as practicable after a concurrent resolution on the budget is agreed to—

(1) the Committee on Appropriations of each House shall, after consulting with the Committee on Appropriations of the other House, (A) subdivide among its subcommittees the allocation of budget outlays, new budget authority, and new credit authority allocated to it in the joint explanatory statement accompanying the conference report on such concurrent resolution, and (B) further subdivide the amount with respect to each such subcommittee between controllable amounts and all other amounts; and

(2) every other committee of the House and Senate to which an allocation was made in such joint explanatory statement shall, after consulting with the committee or committees of the other House to which all or part of its allocation was made, (A) subdivide such allocation among its subcommittee or among programs over which it has jurisdiction, and (B) further subdivide the amount with respect to each subcommittee or program between controllable amounts and all other amounts.

Each such committee shall promptly report to its House the subdivisions made by it pursuant to this subsection.

(c) POINT OF ORDER.—It shall not be in order in the House of Representatives or the Senate to consider any bill or resolution, or amendment thereto providing—

(1) new budget authority for a fiscal year;

(2) new spending authority as described in section 401(c)(2) for a fiscal year; or

(3) new credit authority for a fiscal year;

within the jurisdiction of any committee which has received an appropriate allocation of such authority pursuant to subsection (a) for such fiscal year, unless and until such committee makes the allocation or subdivisions required by subsection (b), in connection with the most recently agreed to concurrent resolution on the budget for such fiscal year.

(d) SUBSEQUENT CONCURRENT RESOLUTIONS.—In the case of a concurrent resolution on the budget referred to in section 304, the allocations under subsection (a) and the subdivisions under subsection (b) shall be required only to the extent necessary to take into account revisions made in the most recently agreed to concurrent resolution on the budget.

(e) ALTERATION OF ALLOCATIONS.—At any time after a committee reports the allocations required to be made under subsection (b), such committee may report to its House an alteration of such allocations. Any alteration of such allocations must be consistent with any actions already taken by its House on legislation within the committee's jurisdiction.

(f) LEGISLATION SUBJECT TO POINT OF ORDER.[2]—

(1) IN THE HOUSE OF REPRESENTATIVES.—After the Congress has completed action on a concurrent resolution on the budget for a fiscal year, it shall not be in order in the House of Representatives to consider any bill, resolution, or amendment pro-

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[2] Section 302(f) became effective April 15, 1986; P.L. 99-177, section 275(a)(2)(A). Until September 30, 1993 the point of order under this section may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn; P.L. 99-177, section 271(b) as amended by P.L. 100-119.

viding new budget authority for such fiscal year, new entitlement authority effective during such fiscal year, or new credit authority for such fiscal year, or any conference report on any such bill or resolution, if—

(A) the enactment of such bill or resolution as reported;

(B) the adoption and enactment of such amendment; or

(C) the enactment of such bill or resolution in the form recommended in such conference report,

would cause the appropriate allocation made pursuant to subsection (b) for such fiscal year of new discretionary budget authority, new entitlement authority, or new credit authority to be exceeded.

(2) IN THE SENATE.—At any time after the Congress has completed action on the concurrent resolution on the budget required to be reported under section 301(a) for a fiscal year, it shall not be in order in the Senate to consider any bill or resolution (including a conference report thereon), or any amendment to a bill or resolution, that provides for budget outlays or new budget authority in excess of the appropriate allocation of such outlays or authority reported under subsection (b) in connection with the most recently agreed to concurrent resolution on the budget for such fiscal year.

(g) DETERMINATIONS BY BUDGET COMMITTEES.—For purposes of this section, the levels of new budget authority, spending authority as described in section 401(c)(2), outlays, and new credit authority for a fiscal year shall be determined on the basis of estimates made by the Committee on the Budget of the House of Representatives or the Senate, as the case may be.

CONCURRENT RESOLUTION ON THE BUDGET MUST BE ADOPTED BEFORE LEGISLATION PROVIDING NEW BUDGET AUTHORITY, NEW SPENDING AUTHORITY, NEW CREDIT AUTHORITY, OR CHANGES IN REVENUES OR THE PUBLIC DEBT LIMIT IS CONSIDERED

SEC. 303. (a) IN GENERAL.—It shall not be in order in either the House of Representatives or the Senate to consider any bill or resolution (or amendment thereto) as reported to the House or Senate which provides—

(1) new budget authority for a fiscal year;

(2) an increase or decrease in revenues to become effective during a fiscal year;

(3) an increase or decrease in the public debt limit to become effective during a fiscal year;

(4) new entitlement authority to become effective during a fiscal year; or

(5) new credit authority for a fiscal year,

until the concurrent resolution on the budget for such fiscal year has been agreed to pursuant to section 301.

(b) EXCEPTIONS.—Subsection (a) does not apply to any bill or resolution—

(1) providing new budget authority which first becomes available in a fiscal year following the fiscal year to which the concurrent resolution applies; or

(2) increasing or decreasing revenues which first become effective in a fiscal year following the fiscal year to which the concurrent resolution applies.

After May 15 of any calendar year, subsection (a) does not apply in the House of Representatives to any general appropriation bill, or amendment thereto which provides new budget authority for the fiscal year beginning in such calendar year.

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PERMISSIBLE REVISIONS OF CONCURRENT RESOLUTIONS ON THE BUDGET

SEC. 304. (a) IN GENERAL.—At any time after the concurrent resolution on the budget for a fiscal year has been agreed to pursuant to section 301, and before the end of such fiscal year, the two Houses may adopt a concurrent resolution on the budget which revises or reaffirms the concurrent resolution on the budget for such fiscal year most recently agreed to.

(b) MAXIMUM DEFICIT AMOUNT MAY NOT BE EXCEEDED.[3]—The provisions of section 301(i) shall apply with respect to concurrent resolutions on the budget under this section (and amendments thereto and conference reports thereon) in the same way they apply to concurrent resolutions on the budget under such section 301(i) (and amendments thereto and conference reports thereon).

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REPORTS, SUMMARIES, AND PROJECTIONS OF CONGRESSIONAL BUDGET ACTIONS

SEC. 308. (a) REPORTS ON LEGISLATION PROVIDING NEW BUDGET AUTHORITY, NEW SPENDING AUTHORITY, OR NEW CREDIT AUTHORITY, OR PROVIDING AN INCREASE OR DECREASE IN REVENUES OR TAX EXPENDITURES.—

(1) Whenever a committee of either House reports to its House a bill or resolution, or committee amendment thereto, providing new budget authority (other than continuing appropriations), new spending authority described in section 401(c)(2), or new credit authority, or providing an increase or decrease in revenues or tax expenditures for a fiscal year, the report accompanying that bill or resolution shall contain a statement, or the committee shall make available such a statement in the case of an approved committee amendment which is not reported to its House, prepared after consultation with the Director of the Congressional Budget Office)—

(A) comparing the levels in such measure to the appropriate allocations in the reports submitted under section 302(b) for the most recently agreed to concurrent resolution on the budget for such fiscal year;

(B) including an identification of any new spending authority described in section 401(c)(2) which is contained in such measure and a justification for the use of such financing method instead of annual appropriations;

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[3] Section 304(b) expires on September 30, 1993; P.L. 99-177, section 275(b)(2)(B) as amended by P.L. 100-119. The point of order under this section may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn; P.L. 99-177, section 271(b).

(C) containing a projection by the Congressional Budget Office of how such measure will affect the levels of such budget authority, budget outlays, spending authority, revenues, tax expenditures, direct loan obligations, or primary loan guarantee commitments under existing law for such fiscal year and each of the four ensuing fiscal years, if timely submitted before such report is filed; and

(D) containing an estimate by the Congressional Budget Office of the level of new budget authority for assistance to State and local governments provided by such measure, if timely submitted before such report is filed.

(2) Whenever a conference report is filed in either House and such conference report or any amendment reported in disagreement or any amendment contained in the joint statement of managers to be proposed by the conferees in the case of technical disagreement on such bill or resolution provides new budget authority (other than continuing appropriations), new spending authority described in section 401(c)(2), or new credit authority, or provides an increase or decrease in revenues for a fiscal year, the statement of managers accompanying such conference report shall contain the information described in paragraph (1), if available on a timely basis. If such information is not available when the conference report is filed, the committee shall make such information available to Members as soon as practicable prior to the consideration of such conference report.

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RECONCILIATION

SEC. 310. (a) INCLUSION OF RECONCILIATION DIRECTIVES IN CONCURRENT RESOLUTIONS ON THE BUDGET.—A concurrent resolution on the budget for any fiscal year, to the extent necessary to effectuate the provisions and requirements of such resolution, shall—

(1) specify the total amount by which—

(A) new budget authority for such fiscal year;

(B) budget authority initially provided for prior fiscal years;

(C) new entitlement authority which is to become effective during such fiscal year; and

(D) credit authority for such fiscal year, contained in laws, bills, and resolutions within the jurisdiction of a committee is to be changed and direct that committee to determine and recommend changes to accomplish a change of such total amount;

(2) specify the total amount by which revenues are to be changed and direct that the committees having jurisdiction to determine and recommend changes in the revenue laws, bills, and resolutions to accomplish a change of such total amount;

(3) specify the amounts, by which the statutory limit on the public debt is to be changed and direct the committee having jurisdiction to recommend such change; or

(4) specify and direct any combination of the matters described in paragraphs (1), (2), and (3).

(b) LEGISLATIVE PROCEDURE.—If a concurrent resolution containing directives to one or more committees to determine and recommend changes in laws, bills, or resolutions is agreed to in accordance with subsection (a), and—

(1) only one committee of the House or the Senate is directed to determine and recommend changes, the committee shall promptly make such determination and recommendations and report to its House reconciliation legislation containing such recommendations; or

(2) more than one committee of the House or the Senate is directed to determine and recommend changes, each such committee so directed shall promptly make such determination and recommendations and submit such recommendations to the Committee on the Budget of its House, which upon receiving all such recommendations, shall report to its House reconciliation legislation carrying out all such recommendations without any substantive revision.

For purposes of this subsection, a reconciliation resolution is a concurrent resolution directing the Clerk of the House of Representatives or the Secretary of the Senate, as the case may be, to make specified changes in bills and resolutions which have not been enrolled.

(c) COMPLIANCE WITH RECONCILIATION DIRECTIONS.—Any committee of the House of Representatives or the Senate that is directed, pursuant to a concurrent resolution on the budget, to determine and recommend changes of the type described in paragraphs (1) and (2) of subsection (a) with respect to laws within its jurisdiction, shall be deemed to have complied with such directions—

(1) If—

(A) the amount of the changes of the type described in paragraph (1) of such subsection recommended by such committee do not exceed or fall below the amount of the changes such committee was directed by such concurrent resolution to recommend under that paragraph by more than 20 percent of the total of the amounts of the changes such committee was directed to make under paragraphs (1) and (2) of such subsection, and

(B) the amount of the changes of the type described in paragraph (2) of such subsection recommended by such committee do not exceed or fall below the amount of the changes such committee was directed by such concurrent resolution to recommend under that paragraph by more than 20 percent of the total of the amounts of the changes such committee was directed to make under paragraphs (1) and (2) of such subsection; and

(2) if the total amount of the changes recommended by such committee is not less than the total of the amounts of the changes such committee was directed to make under paragraphs (1) and (2) of such subsection.

(d) LIMITATION ON AMENDMENTS TO RECONCILIATION BILLS AND RESOLUTIONS.—

(1) It shall not be in order in the House of Representatives to consider any amendment to a reconciliation bill or reconciliation resolution if such amendment would have the effect of increasing any specific budget outlays above the level of such outlays provided in the bill or resolution (for the fiscal years covered by the reconciliation instructions set forth in the most recently agreed to concurrent resolution on the budget), or would have the effect of reducing any specific Federal revenues below the level of such revenues provided in the bill or resolution for such fiscal years), unless such amendment makes at least an equivalent reduction in other specific budget outlays, an equivalent increase in other specific Federal revenues, or an equivalent combination thereof (for such fiscal years), except that a motion to strike a provision providing new budget authority or new entitlement authority may be in order.

(2) It shall not be in order in the Senate to consider any amendment to a reconciliation bill or reconciliation resolution if such amendment would have the effect of decreasing any specific budget outlay reductions below the level of such outlay reductions provided (for the fiscal years covered) in the reconciliation instructions which relate to such bill or resolution set forth in a resolution providing for reconciliation, or would have the effect of reducing Federal revenue increases below the level of such revenue increases provided (for such fiscal years) in such instructions relating to such bill or resolution, unless such amendment makes a reduction in other specific budget outlays, an increase in other specific Federal revenues, or a combination thereof (for such fiscal years) at least equivalent to any increase in outlays or decrease in revenues provided by such amendment, except that a motion to strike a provision shall always be in order.

(3) Paragraphs (1) and (2) shall not apply if a declaration of war by the Congress is in effect.

(4) For purposes of this section, the levels of budget outlays and Federal revenues for a fiscal year shall be determined on the basis of estimates made by the Committee on the Budget of the House of Representatives or of the Senate, as the case may be.

(5) The Committee on Rules of the House of Representatives may make in order amendments to achieve changes specified by reconciliation directives contained in a concurrent resolution on the budget if a committee or committees of the House fail to submit recommended changes to its Committee on the Budget pursuant to its instruction.

(e) PROCEDURE IN THE SENATE.—

(1) Except as provided in paragraph (2), the provisions of section 305 for the consideration in the Senate of concurrent resolutions on the budget and conference reports thereon shall also apply to the consideration in the Senate of reconciliation bills reported under subsection (b) and conference reports thereon.

(2) Debate in the Senate on any reconciliation bill reported under subsection (b), and all amendments thereto and debata-

ble motions and appeals in connection therewith, shall be limited to not more than 20 hours.

(f) Completion of Reconciliation Process.[4]—

(1) In general.—Congress shall complete action on any reconciliation bill or reconciliation resolution reported under subsection (b) not later than June 15 of each year.

(2) Point of order in the house of representatives.—It shall not be in order in the House of Representatives to consider any resolution providing for an adjournment period of more than three calendar days during the month of July until the House of Representatives has completed action on the reconciliation legislation for the fiscal year beginning on October 1 of the calendar year to which the adjournment resolution pertains, if reconciliation legislation is required to be reported by the concurrent resolution on the budget for such fiscal year.

(g) Limitation on Changes to the Social Security Act.—Notwithstanding any other provision of law, it shall not be in order in the Senate or the House of Representatives to consider any reconciliation bill or reconciliation resolution reported pursuant to a concurrent resolution on the budget agreed to under section 301 or 304, or a resolution pursuant to section 254(b) of the Balanced Budget and Emergency Deficit Control Act of 1985, or any amendment thereto or conference report thereon, that contains recommendations with respect to the old-age survivors, and disability insurance program established under title II of the Social Security Act.

NEW BUDGET AUTHORITY, NEW SPENDING AUTHORITY, AND REVENUE LEGISLATION MUST BE WITHIN APPROPRIATE LEVELS

Sec. 311. (a) Legislation Subject to Point of Order.[5]—Except as provided by subsection (b), after the Congress has completed action on a concurrent resolution on the budget for a fiscal year, it shall not be in order in either the House of Representatives or the Senate to consider any bill, resolution, or amendment providing new budget authority for such fiscal year, providing new entitlement authority effective during such fiscal year, or reducing revenues for such fiscal year, or any conference report on any such bill or resolution, if—

(1) the enactment of such bill or resolution as reported;

(2) the adoption and enactment of such amendment; or

(3) the enactment of such bill or resolution in the form recommended in such conference report;

would cause the appropriate level of total new budget authority or total budget outlays set forth in the most recently agreed to concurrent resolution on the budget for such fiscal year to be exceeded, or would cause revenues to be less than the appropriate level of

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[4] Section 310(g) became effective April 15, 1986; P.L. 99-177, section 275(a)(2)(A). Until September 30, 1993, the point of order under this section may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn; P.L. 99-177, section 271(b) as amended by P.L. 100-119.

[5] The portion of section 311(a) which begins with "or, in the Senate" and ends with "paragraph (2) of such subsection" expires on September 30, 1993; P.L. 99-177, section 275(b)(2) as amended by P.L. 100-119. Until September 30, 1991, the point of order under this section may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn; P.L. 99-177, section 271(b).

total revenues set forth in such concurrent resolution or, in the Senate, would otherwise result in a deficit for such fiscal year that—

(A) for fiscal year 1989 or any subsequent fiscal year, exceeds the maximum deficit amount specified for such fiscal year in section 3(7); and

(B) for fiscal year 1988 or 1989, exceeds the amount of the estimated deficit for such fiscal year based on laws and regulations in effect on January 1 of the calendar year in which such fiscal year begins as measured using the budget baseline specified in section 251(a)(6) of the Balanced Budget and Emergency Deficit Control Act of 1985 minus $23,000,000,000 for fiscal year 1988 or $36,000,000,000 for fiscal year 1989;

except to the extent that paragraph (1) of section 301(i) or section 304(b), as the case may be, does not apply by reason of paragraph (2) of such subsection.

(b) EXCEPTION IN THE HOUSE OF REPRESENTATIVES.—Subsection (a) shall not apply in the House of Representatives to any bill, resolution, or amendment which provides new budget authority or new entitlement authority effective during such fiscal year, or to any conference report on any such bill or resolution, if—

(1) the enactment of such bill or resolution as reported;

(2) the adoption and enactment of such amendment; or

(3) the enactment of such bill or resolution in the form recommended in such conference report;

would not cause the appropriate allocation of new discretionary budget authority or new entitlement authority made pursuant to section 302(a) for such fiscal year, for the committee within whose jurisdiction such bill, resolution, or amendment falls, to be exceeded.

(c) DETERMINATION OF BUDGET LEVELS.—For purposes of this section, the levels of new budget authority, budget outlays, new entitlement authority, and revenues for a fiscal year shall be determined on the basis of estimates made by the Committee on the Budget of the House of Representatives or of the Senate, as the case may be.

TITLE IV—ADDITIONAL PROVISIONS TO IMPROVE FISCAL PROCEDURES

BILLS PROVIDING NEW SPENDING AUTHORITY [6]

SEC. 401. (a) CONTROLS ON LEGISLATION PROVIDING SPENDING AUTHORITY.—It shall not be in order in either the House of Representatives or the Senate to consider any bill, resolution or conference report, as reported to its House which provides new spending authority described in subsection (a)(2) (A) or (B) (or any amendment which provides such new spending authority), unless that bill, resolution, conference report, or amendment also provides that such new spending authority as described in subsection (c)(2) (A) or (B) is to be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation Acts.

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[6] The original section 401 was amended in its entirety by P.L. 99-177, section 211.

(b) LEGISLATION PROVIDING ENTITLEMENT AUTHORITY.—

(1) It shall not be in order in either the House of Representatives or the Senate to consider any bill or resolution which provides new spending authority described in subsection (c)(2)(C) (or any amendment which provides such new spending authority) which is to become effective before the first day of the fiscal year which begins during the calendar year in which such bill or resolution is reported.

(2) If any committee of the House of Representatives or the Senate reports any bill or resolution which provides new spending authority described in subsection (c)(2)(C) which is to become effective during a fiscal year and the amount of new budget authority which will be required for such fiscal year if such bill or resolution is enacted as so reported exceeds the appropriate allocation of new budget authority reported under section 302(b) in connection with the most recently agreed to concurrent resolution on the budget for such fiscal year, such bill or resolution shall then be referred to the Committee on Appropriations of that House with instructions to report it, with the committee's recommendations, within 15 calendar days (not counting any day on which that House is not in session) beginning with the day following the day on which it is so referred. If the Committee on Appropriations of either House fails to report a bill or resolution referred to it under this paragraph within such 15-day period, the committee shall automatically be discharged from further consideration of such bill or resolution and such bill or resolution shall be placed on the appropriate calendar.

(3) The Committee on Appropriations of each House shall have jurisdiction to report any bill or resolution referred to it under paragraph (2) with an amendment which limits the total amount of new spending authority provided in such bill or resolution.

(c) DEFINITIONS.—

(1) For purposes of this section, the term "new spending authority" means spending authority not provided by law on the effective date of this Act, including any increase in or addition to spending authority provided by law on such date.

(2) For purposes of paragraph (1), the term "spending authority" means authority (whether temporary or permanent)—

(A) to enter into contracts under which the United States is obligated to make outlays, the budget authority for which is not provided in advance by appropriation Acts;

(B) to incur indebtedness (other than indebtedness incurred under chapter 31 of title 31 of the United States Code) for the repayment of which the United States is liable, the budget authority for which is not provided in advance by appropriation Acts;

(C) to make payments (including loans and grants), the budget authority for which is not provided for in advance by appropriation Acts, to any person or government if, under the provisions of the law containing such authority, the United States is obligated to make such payments to persons or governments who meet the requirements established by such law;

(D) to forego the collection by the United States of proprietary offsetting receipts, the budget authority for which is not provided in advance by appropriation Acts to offset such foregone receipts; and

(E) to make payments by the United States (including loans, grants, and payments from revolving funds) other than those covered by subparagraph (A) (B), (C), or (D), the budget authority for which is not provided in advance by appropriation Acts.

Such term does not include authority to insure or guarantee the repayment of indebtedness incurred by another person or government.

(d) EXCEPTIONS.—

(1) Subsections (a) and (b) shall not apply to new spending authority if the budget authority for outlays which will result from such new spending authority is derived—

(A) from a trust fund established by the Social Security Act (as in effect on the date of the enactment of this Act);

(B) from any other trust fund, 90 percent or more of the receipts of which consist or will consist of amounts (transferred from the general fund of the Treasury) equivalent to amounts of taxes (related to the purposes for which such outlays are or will be made) received in the Treasury under specified provisions of the Internal Revenue Code of 1954.

(2) Subsections (a) and (b) shall not apply to new spending authority which is an amendment to or extension of the State and Local Fiscal Assistance Act of 1972, or a continuation of the program of fiscal assistance to State and local governments provided by that Act, to the extent so provided in the bill or resolution providing such authority.

(3) Subsections (a) and (b) shall not apply to new spending authority to the extent that—

(A) the outlays resulting therefrom are made by an organization which is (i) a mixed-ownership Government corporation (as defined in section 201 of the Government Corporation Control Act), or (ii) a wholly owned Government corporation (as defined in section 101 of such Act) which is specifically exempted by law from compliance with any or all of the provisions of that Act, as of the date of enactment of the Balanced Budget and Emergency Deficit Control Act of 1985; or

(B) the outlays resulting therefrom consist exclusively of the proceeds of gifts or bequests made to the United States for a specific purpose.

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OFF-BUDGET AGENCIES, PROGRAMS, AND ACTIVITIES

SEC. 406. (a) Notwithstanding any other provision of law, budget authority, credit authority, and estimates of outlays and receipts for activities of the Federal budget which are off-budget immediately prior to the date of enactment of this section, not including activities of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds, shall be included in a budget submitted pursuant to section 1105 of title 31, United States Code, and in a concurrent resolution on the budget reported pursuant to section 301 or section 304 of this Act and shall be considered, for purposes of this Act, budget authority, outlays, and spending authority in accordance with definitions set forth in this Act.

(b) All receipts and disbursements of the Federal Financing Bank with respect to any obligations which are issued, sold, or guaranteed by a Federal agency shall be treated as a means of financing such agency for purposes of section 1105 of title 31, United States Code, and for purposes of this Act.

APPENDIX N. COMMITTEE ON WAYS AND MEANS FEBRUARY 1987 AND MARCH 1988 REPORTS TO THE BUDGET COMMITTEE

COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES,
Washington, DC, February 25, 1987.

Hon. WILLIAM H. GRAY III,
Chairman, Committee on the Budget,
U.S. House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: This letter transmits the views and estimates of the Committee on Ways and Means, as required by section 301(d) of the Congressional Budget Act of 1974, on those aspects of the Federal budget for fiscal year 1988 which fall within the Committee's jurisdiction.

In making this report, the Committee on Ways and Means wishes to express its concern about national economic conditions in fiscal year 1988 and beyond. Large budget deficits have been projected, and we believe that serious bipartisan efforts must be made by the Congress and the President to address them.

The huge U.S. trade deficit of nearly $170 billion in 1986 is also of concern and has resulted in large part from the effect of the U.S. budget deficit on interest rates and the value of the U.S. dollar, making it extremely difficult for U.S. companies to compete in the world marketplace. The trade deficit has also been exacerbated by a number of trade barriers maintained by foreign governments which are significantly reducing U.S. export opportunities. As its first major legislative priority the Committee on Ways and Means is working on comprehensive trade reform legislation which will effectively address these foreign trade barriers, make U.S. trade laws more effective in combatting unfair trade practices and provide the authority for a new round of multilateral trade negotiations while encouraging international discussions on monetary reform. We firmly believe that this legislation will pass the Congress this year and will, over time, result in a significant reduction of our trade deficit. Such legislation should have a positive, but at this time, unquantifiable effect on our budget deficit as well.

The Committee on Ways and Means wants to work closely with the House leadership and the House Budget Committee in the development of a fiscal year 1988 budget that significantly reduces the Federal deficit. As in past years, we will make every effort to comply with the Congressional deficit reduction directive to the Committee contained in the fiscal year 1988 budget resolution.

I. Revenues.—The Congressional Budget Office estimates fiscal year 1988 revenues at $900 billion. Last year, the Congress passed H.R. 3838, the Tax Reform Act of 1986, which encompassed a comprehensive structural reform of the Federal income tax system. A major goal of the Act is to reduce the interference of the tax system in the efficient allocation of resources in the economy.

The Act substantially improves tax equity by providing more equal taxation of diverse economic activities. These changes should improve long-term economic growth, eliminate tax-motivated investments and improve economic efficiency. It is in the nation's economic interest to provide a certain and stable environment so individuals and businesses can efficiently and effectively plan for long-term investment which will enhance our productivity and economic growth. The Council of Economic Advisers has concluded that the economy's net national product can be expected to be 0.4 to 2.9 percent larger in the long run due to tax reform's favorable effect on the supply of labor in addition to a small increase expected to result from more efficient use of capital investments. Thus, in the interest of economic stability and concern for the potential of large revenue losses, we will resist any efforts to undo last year's Tax Reform Act.

The Committee expects to report legislation making technical corrections to the Tax Reform Act of 1986 and other legislation within the jurisdiction of the Committee enacted by the 99th Congress. That legislation is not expected to have any significant effect on receipts for fiscal year 1988, not taking into account the receipts attributable to correcting the inadvertent error relating to the ESOP provision. This is not meant to imply that the ESOP correction will be part of the technical corrections bill.

We take note of the fact that the President's budget contains numerous receipt proposals which increase taxes by $5.0 billion; approximately $3.0 billion of these proposals are within the legislative jurisdiction of this Committee. In addition, the Committee notes that the President's competitiveness package contains several revenue initiatives (not included in the budget) whose revenue consequences will have to be carefully scrutinized.

II. Outlays.—The Committee on Ways and Means has jurisdictional responsibility over a broad range of programs. The President's budget contains some $5.7 billion in outlay reductions for fiscal year 1988 in these programs, primarily in the medicare program. In addition, there are several provisions which affect the Aid to Families with Dependent Children (AFDC) program; the Trade Adjustment Assistance (TAA) program is terminated; there are significant reforms in the premium structure of the Pension Benefit Guaranty Corporation (PBGC) and minimum funding requirements; and slightly increased and revised user fees in the Customs Service and the Internal Revenue Service. The Committee and our Subcommittees will carefully review the budget reduction proposals contained in the Administration's budget as well as alternative measures that will reduce Federal expenditures. We obviously will exercise our judgment about precisely where and how the outlay reductions should be achieved.

The Committee wishes to express its concern about the size of the proposed medicare reductions. The Administration has proposed reductions of $4.2 billion in medicare and also proposes to increase part B medicare premiums substantially ($600 million) in fiscal year 1988. The three-year savings for all medicare proposals is approximately $19.5 billion. While the Committee will work diligently in this area, it will not be reasonable to expect providers or beneficiaries to absorb the level of reductions proposed by the Administration in the medicare program for fiscal year 1988.

In addition, the Committee authorizes appropriations for certain trade agencies and programs. The Administration has recommended significant cuts in some of these agencies, particularly in the Office of the U.S. Trade Representative and the U.S. Customs Service. The Committee will consider an authorization bill later this spring, but it is very likely that, in light of our growing trade deficit, the Committee will recommend higher funding levels than proposed by the Administration.

As part of an overall budget deficit reduction effort, the Committee is deeply committed to the concept that outlay reductions be fair and not disproportionately affect any one group of individuals, families, or businesses.

III. New initiatives.—The Administration has also proposed several new initiatives. In the President's budget there is a new dislocated worker program, a new AFDC work and training proposal for teenage recipients, and a new Administration proposal labelled Greater Opportunities through Work (GROW) which would require AFDC recipients to participate in activities to promote their self-sufficiency. In addition, the President has released his catastrophic health insurance proposal, and may soon release his welfare reform proposal.

The Committee expects to legislate in the areas of catastrophic medicare insurance and welfare reform. The Committee will again propose that States provide AFDC to needy children in unemployed two-parent families. While the exact nature and cost of these initiatives are unknown, we anticipate that legislation reported by the Committee on Ways and Means containing these initiatives will be budget neutral. However, the budget should accommodate these new initiatives.

IV. Public debt limit.—The Congressional Budget Office estimates that the fiscal year 1988 unified budget deficit will be $169 billion under current law. The present statutory debt limit is $2.300 trillion, effective until May 15, 1987. In the absence of any legislative action to reduce spending or increase revenue, the debt subject to statutory limit will need to be increased to $2.608 trillion for the period ending September 30, 1988.

V. Additional materials.—As has been our tradition to assist the Budget Committee in carrying out its responsibilities and help it in making assessments concerning the specific recommendations within the jurisdiction of the Committee on Ways and Means, I will send a copy of a Ways and Means Committee Print entitled, "Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means; 1987 edition." This document will include a description of the Administration's fiscal year 1988 budget recommendations under the jurisdiction of the Committee on Ways and Means. This analysis will also include a description of current law, a detailed description of each of the Administration's proposals, CBO and Administration estimates of outlay savings and wherever possible the impact upon program beneficiaries or institutions. I hope you find this information useful. As always, the members of this Committee and its staff are available to answer any questions you may have on any aspect of this report.

With warm regards, I am,

Sincerely yours,

DAN ROSTENKOWSKI, *Chairman.*

COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES,
Washington, DC, March 9, 1988.

Hon. WILLIAM H. GRAY III,
Chairman, Committee on the Budget,
U.S. House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: As required by section 301(d) of the Congressional Budget Act of 1974, this letter transmits the views and estimates of the Committee on Ways and Means on those aspects of the Federal budget for fiscal year 1989 which fall within the Committee's jurisdiction.

In making this report, the Committee on Ways and Means wishes to express its concern about national economic conditions in fiscal year 1989 and beyond. Large U.S. budget and trade deficits exist, and are projected to continue. The huge trade deficit of $171 billion in 1987 resulted in large part from the effect of the U.S. budget deficit on interest rates and the value of the U.S. dollar, making it extremely difficult for U.S. companies to compete in the world marketplace. The trade deficit has also been exacerbated by a number of trade barriers maintained by foreign governments which are significantly reducing U.S. export opportunities.

As its first major priority, conferees from the Committee on Ways and Means and other committees are working to complete the conference on H.R. 3, the omnibus trade reform bill. This legislation will effectively address these foreign trade barriers, make U.S. trade laws more effective in combatting unfair trade practices, provide the authority for a new round of multilateral trade negotiations, and encourage international discussion on monetary reform. We firmly believe that this legislation will pass the Congress this year and will, over time, result in a significant reduction of our trade deficit. Such legislation should have a positive, but at this time unquantifiable, effect on our budget deficit as well.

Immediately after completing the conference on the omnibus trade reform legislation, the Committee will consider legislation to implement the U.S.-Canada free trade agreement. The budget implications of both of these important trade bills should be accommodated in the budget resolution to be reported from your Committee.

I. *Revenues.*—The Congressional Budget Office estimates fiscal year 1989 revenues at $953 billion. The Committee expects to report legislation making technical corrections to the Tax Reform Act of 1986 and other miscellaneous revenue measures. Any such bill reported by the Committee will be budget neutral. We take note of the fact that the President's budget contains several revenue proposals, some of which increase and some of which decrease taxes.

II. *Outlays.*—The Committee on Ways and Means has jurisdictional responsibility over a broad range of programs, including the Medicare program. The Administration's fiscal year 1989 budget proposes an additional $1.3 billion in Medicare reductions, under the pretense that the required Medicare savings agreed to in the economic summit were not achieved. The Committee firmly believes that the required Medicare savings were achieved, and does not intend to consider legislation to achieve additional savings.

The terms of the summit agreement were to reduce Medicare costs by $2.0 billion in fiscal year 1988 and $3.5 billion in fiscal year 1989. Stated another way, the agreement was to increase by $500 million, both in fiscal years 1988 and 1989, the level of Medicare savings contained in the reconciliation bill passed by the House of Representatives on October 29, 1987. In fact, the Medicare reductions in the reconciliation bill signed by the President on December 22 exceeded the targets set by the summit agreement. Provisions in that bill reduced Medicare spending by $2.1 billion in fiscal year 1988, $550 million more than the House-passed bill, and $3.8 billion in fiscal year 1989, over $650 million more than the House-passed bill.

As you know, the Committee also authorizes appropriations for certain trade agencies and programs. The Committee will consider an authorization bill for the Office of the U.S. Trade Representative, the International Trade Commission, and the U.S. Customs Service later this spring.

III. *New Initiatives.*—The Committee expects to complete legislative action on a catastrophic Medicare insurance bill, which is now in conference. Both the President's budget and the Committee assume that this legislation will be budget neutral.

The Committee also anticipates further action on welfare reform during this Congress. As you know, the House has passed a major welfare reform initiative, the Family Welfare Reform Act of 1987 (H.R. 1720). The Senate has not yet acted on welfare reform but is expected to do so in the near future. The President's budget also includes funds for welfare reform. The Committee anticipates that the final welfare reform package will be budget neutral for fiscal year 1989. The Committee anticipates that a further extension of the IRS debt collection provision included in Public Law 100-203 will be used to finance in part the welfare reform bill.

Finally, the Committee notes that H.R. 2167, the Railroad Unemployment Insurance and Retirement Improvement Act of 1987, is currently pending in the Senate. As it passed the House H.R. 2167 had a net savings of $5 million over the first three years and $110 million over five years.

While it is too early to predict the exact nature and costs of these new initiatives, the Committee expects that the budget resolution will accommodate the catastrophic health insurance bill and welfare reform. As noted above, the Committee anticipates that both initiatives will be budget neutral with respect to programs within the jurisdiction of the Committee.

IV. *Reconciliation.*—The Committee strongly urges that no reconciliation directive to achieve further outlay savings or revenue increases be assigned to the Committee. However, if the Administration, in compliance with the requirements of the amended Gramm-Rudman-Hollings law, produces a budget deficit estimate on August 25th of this year reflecting the need for further deficit reduction efforts, this Committee stands ready to consult with the leadership about the appropriateness of further deficit reduction efforts and to assist the leadership in undertaking any deficit reduction efforts deemed appropriate.

V. *Public debt limit.*—The Congressional Budget Office estimates that the fiscal year 1989 unified budget deficit will be $176 billion under current law. The present statutory debt limit is $2.8 trillion, a level that the Committee projects will be sufficient through mid-1989. Thus, the Committee does not anticipate any legislative action on the public debt limit this year.

VI. *Additional materials.*—In keeping with our tradition of assisting the Budget Committee in carrying out its responsibilities and in making assessments concerning specific recommendations within the jurisdiction of the Committee on Ways and Means, I will forward at a later date a copy of a Ways and Means Committee print entitled, "Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means: 1988 Edition." This document will include a description of the Administration's fiscal year 1989 budget recommendations under the jurisdiction of the Committee on Ways and Means. I hope you find this information useful. As always, the members of this Committee and its staff are available to answer any questions you may have on any aspect of this report.

With warm regards, I am

Sincerely yours,

DAN ROSTENKOWSKI, *Chairman.*

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